University of Alberta

Connecting Spiritually: How Nurses Learn to Care for Spiritual Needs

by

Louise Elizabeth Hood ©

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CHAPTER 1

INTRODUCTION

The influence of spirituality, spiritual needs, and spiritual care on human health has not been well understood among modern nurses. Following the example of medicine and biomedical science, the discipline and practice of nursing generally separated spiritual issues from other matters of human health. Most commonly, nurse researchers avoided doing studies related to issues of a spiritual nature, and instead concentrated on biopsychosocial problems (Narayanasamy, 1999b). Moreover, few researchers have explored how nurses learn about spiritual care. Only recently have a growing number of nurses begun to be more cognizant of clients' specific spiritual needs. Despite a mandate to provide spiritual care, nurses generally do not understand what distinguishes spiritual issues from psychological, sociocultural, or religious issues (Burkhart & Solari-Twadell, 2001; Coyle, 2002). Consequently, considerable confusion persists among nurses as to how to address clients' spiritual needs.

Many nurses mistakenly believe that religion and, by extension, spirituality are particularly private matters and, somehow, beyond the scope of nursing practice. Generally, this prevalent misunderstanding has resulted in an implicit, if not deliberate, avoidance of spiritual matters in nursing practice. Consequently, human spirituality and spiritual needs are often neglected aspects of health care. However, even with historical reluctance, nurses around the world are being increasingly mandated to intervene within the spiritual dimension. Edicts to ensure spiritual care have appeared in legislation, codes of ethics, standards for practice, and criteria for institutional accreditation (Harrington, 1995; International Council of Nurses, 2000; Maddox, 2001; McSherry, 2000a; Summer, 1998). To this end, a growing number of texts about spiritual assessment and intervention (Barnum, 1996; Burkhardt & Nagai-Jacobson, 2002; Carson, 1989; Clark & Olson, 2000; Harrison & Burnard, 1993; O'Brien, 1999; Shelly & Fish, 1988; Taylor, 2002) have recently appeared in the nursing literature. Yet, despite the abundance of relevant literature and directives for spiritual care, many practicing nurses still reported feeling uncertain about and unprepared to intercede in clients' spiritual needs (Greasley, Chiu, &

Gartland, 2001; Harrington, 1995; McSherry, 1998, 2000b; Narayanasamy, 1993, 1999a; Narayanasamy & Owens, 2001; Tuck, Pullen, & Lynn, 1997).

Many nursing scholars have studied the concept of human spirituality (Burkhardt, 1989; Coyle, 2002; Goddard, 1995; Hood Morris, 1995; Martsolf & Mickley, 1998; Reed, 1992). Related concepts or constructs such as spiritual dimension (Olson et al., 2003; Stoll, 1989; Thomas & Retsas, 1999), spiritual perspective (Hasse, Britt, Coward, Leidy, & Penn, 1992; Taylor, Highfield, & Amenta, 1999), spiritual well-being (Hood Morris, 1996; Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1985), spiritual needs (Oldnall, 1996; Ross, 1997a; Soeken & Carson, 1987; Stephenson, Draucker, & Martsolf, 2003; Strang, Strang & Ternestedt, 2002), and spiritual distress (Craft-Rosenberg, Delaney, Denehy & NDEC Research Team, 1999; Georgesen & Dungan, 1996; Hensley, 1994; Kim & Moritz, 1982; McHolm, 1991; Pehler, 1997; Smucker, 1996; Twibell, Wieseke, Marine, & Schoger, 1996; Weatherall & Creason, 1987) have also been described and analyzed. Among these works, spirituality was described as a journey, an essence, an awareness (Narayanasamy, 1999a); an energy (Goddard, 1995); a motivating force (Nagai-Jacobson & Burkhardt, 1989); a resource (Reed, 1992); a meaningful belief (Soeken & Carson, 1987); a guiding philosophy (Ellerhorst-Ryan, 1985); a sense of connection (Burkhardt & Nagai-Jacobson, 2002); and an experience (Hood Morris, 1995) "of being in relationship with . . . a special person, deity, or some object of meaning" (Clark, 2000, pp. 20-21). However, no clear conceptual consensus has yet appeared in the literature with regard to the definition of human spirituality.

In an attempt to gain conceptual clarity, research has focused on the various components perceived to be part of spirituality. For example, work on such constructs as inner strengths, unfolding mystery, and harmonious interconnectedness (Burkhardt, 1989; Burkhardt & Nagai-Jacobson, 2002) began to appear more consistently in the literature. However, to this point this work has not translated into a substantial increase in the clarity of the overarching concept of spirituality amongst nurses. Without a clear understanding of human spirituality, it is difficult for nurses to identify and assist with spiritual needs. Consequently, misunderstanding about spiritual care practices has prevailed.

Professional nursing practice requires knowledge pertaining to spiritual assessment, diagnosis, intervention, and evaluation. To assist nurses, some tools for spiritual assessment and diagnosis have been developed. Initial assessment and diagnostic prototypes, however, reflected the common belief that spirituality was the same as religion and showed a strong Judeo-Christian bias (Peterson & Nelson, 1987; Stoll, 1979). As a result, nurses using these original tools may have been able to capture a portion of some clients' spiritual concerns but missed other crucial intra- and interpersonal manifestations of spiritual need. More recent tools represent a broader, more inclusive spiritual orientation (Carpenito, 2002; Dossey, 1998; Highfield, 1993; Highfield & Cason, 1983). Coached in nonreligious language, newer tools and diagnoses (North American Nursing Diagnosis Association, 1999) address more fully the essential spiritual quality of interconnectedness between the client and the Mystical Beyond (or God) as well as between self, others, and the rest of the natural world. Despite these advances, research has indicated that relatively few nurses intentionally incorporate knowledge related to human spirituality into the process of nursing practice (Harrington, 1995; Stranahan, 2001). When included, spiritual care is most often done at an unconscious level (Golberg, 1998).

Whether nurses are aware that they are intervening in spiritual needs or not, nurses generally enact spiritual care during routine care through being attentive and fully present with a client (McKivergin, 2000). Spiritual care occurs when a nurse enters the patient's experience; shares an individual's pain; listens; raises necessary questions; is a companion; accepts self and others; facilitates change; encourages the exploration of values, goals, and personal views; allows others to make their own decisions; and treats the patient in a professional manner that includes reflection, presence, love, crying, rejoicing, and sharing (Narayanasamy, 1999b).

To help understand how nurses learn to care for spiritual needs, several researchers have explored nurses' perceptions of spiritual care (Harrington, 1995; Hood Morris, 1995; McSherry, 1998; O'Brien, 2003; Ross, 1997b; Stranahan, 2001). However, from a client perspective, although perceptions of general nursing care existed, few researchers specifically explored client experiences of spiritual care (Hood Morris, 1995). Several studies have been conducted about various aspects of learning related to spiritual care in certain educational settings. However, beyond the context of formal education, no nursing studies have described the contributing factors and process for acquiring and maintaining continuing competencies related to caring for spiritual needs.

It has been suggested that nurses draw on their own spirituality, or faith traditions, for knowledge to guide the practice of spiritual care (O'Brien, 1999, 2003; Taylor et al., 1999). Ways of obtaining knowledge for giving spiritual care, other than one's own spirituality or faith experience, have been less clearly noted in the literature. Some authors have explored educational issues associated with teaching the complex nature of spirituality (Gallia, 1996; Greenstreet, 1999; McSherry, 2000a; McSherry & Draper, 1998; Narayanasamy, 1999a; Piles, 1980) and strategies for teaching content-specific spirituality courses (Groer, O'Connor & Droppleman, 1996; Harrison & Burnard, 1993). Faculty in a growing number of Canadian nursing education programs have begun to look at the place of spirituality within the curriculum (Olson et al., 2003). Many schools and faculties of nursing have attempted to embed information on spirituality and spiritual care throughout the standard curricula rather than developing separate courses (Bush, 1999; Catanzaro & McMullen, 2001; Maddox, 2001; Pesut, 2002; Piles, 1980).

Thus far, research on the development of knowledge for spiritual care has been conducted exclusively in the domain of formal education. However, McSherry (2000b) and others have suggested that knowledge for spiritual care was best acquired in the practice setting. The optimal sources, places, and mechanisms for nurses to learn about spirituality and spiritual care remain unclear. Thus, in light of conceptual confusion, uncertainty about how to meet patients' spiritual needs, and a growing mandate to provide spiritual care, theory capturing the ways, means, and processes by which nurses learn to give spiritual care needs to be generated.

Purpose

This study explored how registered nurses acquire knowledge for spiritual care. Because little information exists on the process of learning about and using knowledge for spiritual care after entry into practice, the study focused mainly on the experience of post registration nurses practicing in a broad range of settings. The purpose of the study, then, was to construct a grounded theory that explained the process by which nurses come to understand and use knowledge related to spirituality and spiritual care.

Significance

The findings from this study will assist in the clarification of the ways, methods, and processes that nurses use to acquire knowledge and learn skills related to spiritual care. The study will also help to sensitize nurses and others to the human need for spiritual care and makes more apparent the spiritual component of nursing practice. As well, by bringing the process of acquiring knowledge for spiritual care into the conscious awareness of practicing nurses, overall patient care may improve (Golberg, 1998).

CHAPTER 2

LITERATURE REVIEW

The purpose of this literature review is to locate the current study in the context of the nursing literature on the concept of spirituality and knowledge development associated with spiritual care in nursing practice. In a review of the literature, several themes emerged. First, conceptual confusion exists over the multiple constructs, manifestations, and variables of spirituality and between spirituality and the closely related concepts of religion, faith, and theology (Clark, 2000). Other themes include education for spiritual care, the practice of spiritual care, and client perception of care.

Confusion Over the Concept of Spirituality

A great deal of confusion exists in nursing about the nature and parameters of spirituality and the role of nurses in spiritual care (Burkhart & Solari-Twadell, 2001; Golberg, 1998). Since the early 1970s the combined efforts of authors such as Hungelmann et al. (1985), Burkhardt (1989), Hasse et al. (1992), and Hood Morris (1995) showed steady progress towards defining spirituality and its various aspects. Their work identified three seminal constructs of spirituality: purpose, meaning, and connection. Burkhart and Solari-Twadell defined *spirituality* as an "experience of and integration of meaning and purpose in life through connectedness with self, others, art, music, literature, nature, or a power greater than oneself" (p. 49). Yet this work has not been well integrated into theoretical models used to guide nursing practice.

The concept of spirituality in fact was rarely addressed in the many conceptual frameworks for nursing (Martsolf & Mickley, 1998; Oldnall, 1996). Moreover, seminal guides for critiquing nursing theories (Fawcett, 2000; Fitzpatrick & Whall, 1996) neglected to include human spirituality in their evaluation criteria. Consequently, most books about nursing theories and models (George, 1995; Parker, 2001; Tomey & Alligood, 1998) either failed to address or addressed very minimally aspects of spirituality and spiritual care. In general, conceptualizations of nursing offered little guidance for concept clarification. One exception was Watson's (1988, 1999) theory of human caring in which spirituality is a central theme associated with her notion of transpersonal caring. Although not well known by nurses, her conceptual framework offered considerable insight into the nature of spirituality and the practice of nursing care (Hoover, 2002). This overall lack of a theoretical foundation contributed to the conceptual confusion and uncertainty that many nurses experienced in trying to understand spirituality and spiritual care.

Distinguishing Spiritual Needs From Psychosocial Variables

Many nurses seemed uncertain about what distinguishes spiritual needs and other aspects of spiritual care from physical and psychosocial needs and care (Engebretson, 1996; McNamara, 1995; Piles, 1980). Piles (1990) distinguished psychosocial care from spiritual care by limiting spiritual needs to those associated with "a person's relationship, or lack of relationship, with God" (p. 39). Others conceived spirituality and spiritual needs more broadly, including concern for intra- and interpersonal connections. Hall (1998) found that most nurses favored an intrapersonal approach to spiritual care that focused on needs such as fostering the potentiality of self, a capacity for knowing, and inner strength. Psychological variables such as hope, peace, worth, and well-being were often mixed with notions of spirituality and used interchangeably with spiritual needs such as faith, empowerment, meaningfulness, and connection (Burkhardt & Nagai-Jacobson, 2002; Carrigg & Weber, 1997; Goddard, 1995; Golberg, 1998). Many authors argued that spirituality, spiritual needs, and spiritual care cross the traditional human-dimensional boundaries of physiology, psychology, and sociology (Neuman, 1995; Reed, 1992). Spiritual needs were not distinguished from, but generally conceived of and interwoven with, biopsychosocial needs and care. Documentation of spiritual care, however, was rare. With such conceptual confusion, it is little wonder that practicing nurses had difficulty recognizing or acknowledging spiritual needs and other aspects of spiritual care (O'Brien, 1999; Twibell et al., 1996).

Spirituality and Religion

Until recently, nurses normally did not differentiate between the concepts of spirituality and religion. In comparison to the meaningful and broadly connective notions of spirituality, religion pertains to an "understanding of a particular faith system or dogma and participation in the rituals and services offered by a faith community" (Burkhart & Solari-Twadell, 2001, p. 49). As a result of this lack of differentiation, most tools developed by nurses to assess spiritual well-being reflected religious, and primarily monotheistic, assumptions (Hood Morris, 1996). Consequently, nurses' spiritual care was often limited to prayer or referral to clergy (Stranahan, 2001; Taylor et al., 1999). More recently, in British hospitals spiritual care began to embrace the broader and more diverse perspective of whatever is meaningful in the patient's life (Walter, 1996). The patient's perspective began to be included with the traditional religious or ecclesiastical approaches to spiritual care. Moreover, Tuck, Wallace, and Pullen (2001) reported that, along with the religious as a category of spiritual interventions, parish nurses include interactional, relational, and professional categories. Therefore, moving from a conventional approach that tended to fuse religion and spirituality, nurses in the past several decades have begun to redefine spirituality with a more inclusive social science perspective. Previously, nurses thought that spirituality exclusively meant the Judeo-Christian notion of religion and relationship with God. Now nurses tend to embrace a broader notion of the Divine more generally as a value or principle that gives meaning and purpose (Coyle, 2002).

In addition to the transpersonal, or God-connectedness, aspect of religion and/or spirituality, nurses are beginning to shift their understanding of spirituality towards conceiving intrapersonal and interpersonal aspects as well. The intrapersonal focus of spirituality includes facilitating self-potential, knowledge, and inner strength (Hall, 1998). The interpersonal aspect relates to connection and interaction with other humans and the natural world (International Council of Nurses, 2000; Narayanasamy, 1999a; Reed, 1992). Gradually, the similarities and differences between religion and the broader concept of spirituality are becoming more apparent. More and more, spirituality is appearing in definitions of human health and nurses are trying to respond to a growing mandate to provide evidence-based spiritual care.

Education and Knowledge for Spiritual Care

Education for spiritual care is important for the development of evidence-based practice. In a recent study exploring the extent to which the spiritual dimension was addressed in Canadian university schools of nursing, Olson et al. (2003) found that, on the whole, spirituality was rarely included, let alone defined, in curricular objectives. When it did occur, it tended to be found in specific course objectives or taught sporadically by educators with a specific interest in spirituality and spiritual care.

In spite of the conceptual confusion and lack of curricular attention, nursing students and educators have access to a growing body of nursing literature related to human spirituality and spiritual care (Narayanasamy, 1999a). Along with a few early texts (Carson, 1989; Shelly & Fish, 1988; Harrison & Burnard, 1993), several books specifically pertaining to spirituality and nursing have appeared recently (Barnum, 1996; Burkhardt & Nagai-Jacobson, 2002; Clark & Olson, 2000; McSherry, 2000b; O'Brien, 1999, 2003; Taylor, 2002). The literature includes studies pertaining to course and curriculum content, teaching strategies, and student perceptions of spiritual care. For instance, Greenstreet (1999) suggested that curricula on spiritual care should include themes of hope, forgiveness, meaning, purpose, and loving relationships. In addition, McSherry (2001) emphasized the need to explore the impact of cultural influences on the experience of illness, suffering, near death, and other spiritual phenomena. Examining the literature was only one strategy for implementing spiritual care.

The most common learning strategy to acquire knowledge for spiritual care seems to have been spiritual self-reflection (Bush, 1999; Catanzaro & McMullen, 2001; Groer et al., 1996; Lebold & Douglas, 1998; Narayanasamy, 1999a; Piles, 1980). In particular, journaling (Moll & Cook, 2001) and the safe peer milieu of pre-/postclinical conferences (Catanzaro & McMullen, 2001; Olson et. al, 2003) were considered useful mediums to foster personal reflection. In addition to examining the nursing literature, other strategies for learning included facilitating discussion of issues, teaching others (Catanzaro & McMullen, 2001), meditation, case studies, faculty role modeling (Olson et. al, 2003), interdisciplinary panels (Groer et al., 1996; Melland & Clayburgh, 2000), and exploring ideas from related disciplines such as philosophy, theology, and the social sciences (Narayanasamy, 1999a). No studies were found that specifically examined the influence of a broad liberal arts program of study on the acquisition of knowledge related to spirituality and nursing care.

Gallia (1996) pointed out that teaching and learning specific content for spiritual care are insufficient without the fostering and acquisition of certain personal attributes. To accomplish this, teachers were encouraged to role-model "being present." Presence entails being balanced (caring for self), being held (experiencing a supportive environment), and being sustained (developing a subjective sense of support which fostered an ability to use strengths and abilities in adverse situations). Learning to be present with a client leads the student to a genuine appreciation of the client's perspective through the attribute of connection. Connection, along with meaning and purpose, manifest human spirituality. Students exploring course material related to spiritual care often reported a growing sense of personal development and spiritual awareness (Bush, 1999; Hoover, 2002; Pesut, 2002). Similarly, practicing nurses reported personal benefit from providing care based on spiritual principles (Bush, 1999; O'Brien, 1999). However, the literature did not address whether or not the ways and means of acquiring attributes for spiritual care varied from the academic to the practical realm.

Nurses' Practice of Spiritual Care

Due in part to the traditional dominance of a medical agenda that valued observable and measurable components of care over personal components (Greasley et al., 2001), nurses generally felt hesitant to provide more personal, subjective, and less tangible forms of care. Because spiritual outcomes are less measurable, nurses seemed uncertain about the effectiveness of their spiritual care (McSherry, 1998). As well, many believed that their formal education did not prepare them to intervene with spiritual matters (Narayanasamy, 1993). Consequently, the approach to spiritual care is often individualistic, disorganized, and delivered haphazardly (Harrington, 1995; Narayanasamy & Owens, 2001). Moreover, although some nurses value spiritual care, and even consider it the core of nursing activity (Dossey, Frisch, Guzzetta, & Burkhart, 1994; Robertson, 1994; Watson, 1999), it remains largely unrecognized and unacknowledged (O'Brien, 1999). For instance, in a study by Tuck et al. (1997), few nurses were able to describe specific examples of spiritual care interventions. Similarly, American nurse practitioners reported that, despite receiving some education related to spirituality, more than half rarely, if ever, attended to spiritual needs (Stranahan, 2001).

Thus, spiritual needs generally have not been conscientiously attended to by practicing nurses.

Despite the general lack of recognition and attention to spiritual needs, a growing number of nurses believe that spiritual care is the essential component of nursing practice. Effective spiritual care helps a client discover personal meaning in illness events and can be pivotal to a client's response to other experiences of life (Govier, 2000; Oldnall, 1996). Therefore, whereas spiritual needs pertain to the development of meaning and purpose, spiritual care relates to the quality of interpersonal love and compassion (Greasley et al., 2001). In addition, Kendrick and Robinson (2000) found that the attitude and manner of a nurse contributed to the effectiveness of care. The notion of "beneficent attending" (Kendrick & Robinson, 2000, p. 703) conjures an image of mutuality and reciprocity in the context of professional caring for spiritual concerns. Genuine compassion and connection found in the context of a relationship that explores meaning and purpose are hallmarks of spirituality and spiritual care.

Practicing nurses described varying activities and outcomes associated with spiritual care. Spiritual care activities include entering and companioning another's pain, actively listening, facilitating reminiscence, raising necessary questions, loving, accepting, facilitating change, empowering another to take action, facilitating contact with a spiritual/religious support system, reading Scripture, praying, crying, rejoicing, and sharing (Georgesen & Dungan, 1996; McNamara, 1995; Narayanasamy, 1999b; O'Brien, 1999; Tuck et al., 1997; Wesorick, 1995). Some nurses gave examples of specific spiritually oriented ways of knowing that often provide useful information for implementing the nursing process. For example, 67% of a random sample of nurses reported supernatural "spiritual experiences" such as premonitions, seeing pain in colors, seeing the deceased, and feeling "lifted" (Lewis, 1987, p. 42) in the presence of God. Spiritual caregiving results in clients' increased sense of comfort and security (McNamara, 1995) and, for some nurses, an appreciation of what it means to be an instrument of spiritual healing (Wilt & Smucker, 2001). Many nurses reported a reciprocal benefit from the act of providing spiritual care (Kendrick & Robinson, 2000; McNamara, 1995; O'Brien, 1999).

Clients' View of Spirituality and Spiritual Care

Client perceptions of various aspects of spirituality were explored in only a few studies. From descriptions of patients with terminal cancer, Thomas and Retsas (1999) developed a grounded theory of spirituality in the context of facing death. "Transacting self-preservation" (p. 191) entailed a three-phase process of taking in, getting on with, and putting together the meaning of life's experiences. Smucker (1996) explored the nature of spiritual distress and, similar to Thomas and Retsas, discovered that participants perceived spiritual distress as a two-part process of breaking down and rebuilding that proceeded from distress, to change, to growth. Fewer studies pertained specifically to client perceptions of spiritual care. Georgesen and Dungan (1996) studied the effects of spiritual care on patients with advanced cancer pain. All clients experienced spiritual distress, as evidenced by grief. As a result of nurses' presence, caring, genuine concern, and active listening, "all clients increased hope, participated in the grief process, and integrated the possibility of death in such a way as to promote personally defined 'quality of life' through their waning days" (p. 376). However, several participants in a study by Hood Morris (1995) reported that they believed that nurses had "no idea" of the positive effect of their spiritual-care interventions on the person's sense of well-being. Thomas and Retsas concluded that spiritual support might mean nothing more than simply "taking the time to provide physical and psychosocial caring that touches the spirit" (p. 200). Although some literature suggested that clients perceive spirituality as a transformative process, generally, a gap exists with regard to client perceptions of the effects of receiving spiritual care.

The Process of Acquiring Knowledge for Spiritual Care

As demonstrated, a growing body of literature exists about spirituality and spiritual care. However, there is scant information about the actual means and processes that registered nurses use to acquire the knowledge and skills for competent spiritual care. The reasons cited for the historic reluctance to learn about and practice spiritual care include lack of formal education opportunities, fear of invading another's privacy, lack of adequate time, and lack of awareness of one's own spirituality (Wright, 1998). Other reported barriers included political, cultural, economic, and environmental constraints

(McSherry, 2000b). In addition to these excuses, nurses often fail to recognize when simple spiritual needs actually were being addressed. In her observations of practicing nurses, even though Golberg (1998) found evidence of spiritual care as described in the literature, those same nurses were generally not able to describe specific spiritual caregiving events. Another reason for this lack of awareness may have been related to the paucity of explicit descriptions of spirituality and spiritual care in the theories of nursing (Kendrick & Robinson, 2000; Martsolf & Mickley, 1998; Oldnall, 1996; Rassool, 2000). Overreliance on previously cited anecdotal evidence in other nursing literature has also contributed to the impression that nurses lack knowledge and preparation to intervene in spiritual needs (Oldnall, 1996).

Aside from several studies set in formal education settings, few nurse scholars have investigated other modes, methods, places, and times for nurses to learn about spirituality and spiritual care. The nursing literature rarely accounted for nonnursing sources of knowledge such as exposure to the teachings of exemplary spiritual figures. One exception is Rassool (2000), who suggested that an understanding of caring can be learned by nurses through studying attributes of Allah found in the Koran. Similarly, as a novice nurse who concurrently adopted a new faith tradition and graduated from a hospital-based diploma nursing program in the early 1970s, Hood Morris (1995) described being confused about whether some of her caring practices stemmed from her religious or her nursing knowledge. She recognized that knowledge for spiritual care arose from sources other than her formal nursing education but was confused about the legitimacy of using this knowledge in her nursing practice.

Catanzaro and McMullen (2001) suggested that spirituality and spiritual care could not merely be taught; they had to be incorporated into a way of being in life. Similarly, McSherry (2000a) contended that spirituality is best "caught" (p. 41) through exposure in clinical practice. This implies the existence of different sources and stages of knowledge development. This assumption was further substantiated by Pesut (2002), who compared first- and fourth-year nursing students and found that senior students demonstrated a much more client-centered approach to spiritual care than did novice students. First-year students often focused on their own agenda and tried to influence client beliefs. Senior students were able to support clients better in the exploration of beliefs in relation to their experiences with health and illness. As well, the influence of personal and professional experience on spiritual care practices remains unclear (Taylor et al., 1999). Tuck et al. (1997) found that, in a sample of mental health nurses over 40 years of age, they received higher scores on a spiritual-perspective measure. This implies that one's spirituality develops and matures as one grows older. From this, it appears that the knowledge and skills required to address spiritual needs also might change over time and with exposure to different learning resources. No studies were found that explored the ongoing process in which practicing registered nurses engage while gaining the knowledge needed for spiritual care.

Research Question

In this study the broad area (Glaser, 1992) of how nurses come to understand and practice spiritual care was explored. In order to be open to discovering what is really going on as registered nurses go about acquiring knowledge for spiritual care, I refrained from approaching the study from the perspective of a particular problem to be solved. There were no specific preconceived research questions. Instead, the initial guiding queries were as follows: For registered nurses, what is the process of acquiring knowledge for spiritual care? How do nurses conceive spiritual care? What are the sources of knowledge for spiritual care? How do nurses learn about caring for the human spirit? Does the practice of spiritual care evolve over time? If so, in what way?

CHAPTER 3

METHOD

To explore how practicing registered nurses acquire knowledge for spiritual care, I employed a grounded theory methodology, as originally described by Glaser and Strauss (1967) and further developed by Glaser (1978, 1992) and others (Charmaz, 2000; Morse, 2001; Stern, 1980, 1994; Wilson & Hutchinson, 1996, Wuest, 2000). I chose this method because grounded theory fosters an investigation of a core process pertaining to what is actually going on in a group as they engage in and handle an issue (Glaser, 1992). Consistent with Glaserian grounded theory, the inquiry began broadly without theoretical preconception and focused on discovering the basic social psychological process (Charmaz, 2000; Glaser, 1978, 1992; Stern, 1994; Wilson & Hutchinson, 1996) associated with how nurses learn to care for the spiritual needs of others.

Setting

The setting for this study included anywhere that registered nurses practiced direct patient care. Participants for the study were recruited mainly from within an urban health region in Western Canada. Because the purpose of the study was to generate a substantive theory of how registered nurses who engaged in direct clinical practice acquired knowledge for spiritual care, there were no restrictions in practice settings or sites.

Sample

Sample participants were chosen based on the principles of purposive sampling and theoretical sampling (Glaser, 1978). After each person contacted me, I asked for basic screening information such as what had prompted them to seek information and in what clinical areas they had practiced nursing. As I spoke with potential participants, I screened them for the ability to articulate their thoughts. Successively, I selected interviewees with certain purposes in mind. Initially, participants were sought to provide broad exploratory information related to acquiring knowledge for spiritual care. For example, one of the first people interviewed was a knowledge expert (Glaser, 1978) in the practice of spiritual care. Participants were then selected based on their ability to best provide insight relevant to codes and categories and related properties and connections found during ongoing analysis of the previously collected data. Glaser and Strauss (1967) described this process of theoretical sampling as

> the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his [/her] data and decides what data to collect next and where to find them, in order to develop his [/her] theory as it emerges. (p. 45)

Therefore, sample selection was contingent on the needs of the emerging theory.

Of the 27 individuals who expressed interest in volunteering for the study, 14 registered nurses and 1 pastoral care professional were selected. Based on constant comparative analysis of the data, participants were sought to describe incidents pertaining to spiritual care and the ways and means of acquiring knowledge for that practice. All were female, and their ages ranged from 25 to 64 years, with more than half over 50 years of age. All but one had begun their nursing careers at diploma-granting colleges or in hospital-based nursing programs. Twelve of the 15 participants continued their formal nursing education after entry-level studies. About half studied a variety of nonnursing programs, including pastoral care, arts, science, and education. The number of years since entry into nursing ranged from 2 to 43, with a mean of 22 years. Clinical experience included a spread between various acute care, community, and industry settings. As well, although it was not specifically sought, a few participants provided information from the perspective of a researcher, manager, or educator.

In addition to direct interviews, all participants were invited to submit any written thoughts related to the study that may have occurred to them after the interview. A storyline memo (see Appendix A), representative of the collective story, was constructed after analysis and sent to the participants for feedback. In these cases, the written information was treated in the same way as the data arising from interviews.

Permission to recruit nurses was sought and granted from authorities in the health region. Strategies for recruitment included posters placed in locations where nurses meet (see Appendix B), two electronic ads, and one advertisement in a faith organization's newsletter. As well, through the use of a word-of-mouth snowball technique, some participation arose from direct referral from other participants or nurses. I anticipated that some nurses would tell me that they learned about spiritual care during their formal nursing education program. If that had happened, consistent with the strategy of theoretical sampling, some student nurses would have been recruited to enable me to gain an understanding of that portion of the process of acquiring knowledge for spiritual care. Permission to recruit students was obtained from the Dean of the University of Alberta Collaborative Baccalaureate Nursing Program. However, as the study unfolded, the recruitment of student nurses became unnecessary to understand the research question.

Once I identified some codes, categories, and relationships through open coding of the initial few interviews, the sampling process proceeded based on the selection of participants related to the central issues of the emerging theory. Prior to beginning the research, I did not determine precisely for what I wanted to sample, where to look, and where the process would lead (Glaser, 1978). Instead, proceeding with theoretical sensitivity, I received guidance for sample selection from the conceptually induced codes that arose from previous data. To inform the process of theoretical sampling, I constantly compared these data with other data. Through theoretical sensitivity and purposive sampling, the theory was "rooted in data not an existing body of theory" (Glaser, 1978, p. 38). For example in the beginning, because of the historical confusion between religion and spirituality, I did not specifically collect information about the participants' identified faith traditions. However, from the constant comparative analysis and especially after the sixth interview, the influence of religious teachings on learning became an issue for theoretical sampling. All of the participants until then had voluntarily indicated a strong connection to some form of Christianity. One participant asserted her belief that spiritual care pertains mainly to helping patients get in touch with Jesus and that the only true way to be spiritually well is to be associated with God in the way that she had experienced. I was led by the data to wonder whether nurses with different faith traditions or nonreligious nurses would describe notions of spirituality and spiritual care in a similar or a different manner. As a consequence, I sought nurses from outside the various Christian belief systems and selected additional participants who described their faith traditions as Wicca, eclectic, and nonreligious to inform questions that arose from earlier interviews.

Data Collection and Data Analysis

Strategies to collect and analyze data were consistent with a Glaserian grounded theory methodology (Glaser, 1978, 1992). Stern (1980) described the steps of the research process as collection of empirical data, concept formation, concept development, and concept modification and integration. Without preconceived hypotheses or a framework of concepts, yet being theoretically sensitive, I approached the study with complete openness and confidence in my data (Glaser, 1978). That meant, through an intertwined analytic process of suspending judgment, asking what was really happening in the data, collecting specific theoretically sensitive data, comparing findings with related data, and continuously challenging my appraisal, I focused on discovering the actual meaning embedded in the data.

First, I generated data through tape-recorded interviews with knowledgeable registered nurses. I began by using open-ended, broad exploratory questions such as, "Tell me about a time when you practiced spiritual care? What prepared you to provide spiritual care? How did you acquire the knowledge for spiritual care?" Remaining open and receptive, I assisted the participants in relating whatever they saw as important or relevant about spirituality and acquiring knowledge for spiritual care. During the course of data collection, I modified the question according to how the participants responded (Glaser, 1978). For instance, during the first few interviews I began by asking for an example of a time when the participants provided spiritual care and followed up with questions on how they had learned to practice in that way. It became evident that the participants were focusing more on what spiritual care was rather than on how it had been learned, and I adjusted the initial question to reflect better the main topic of inquiry by saying, "I'd like to ask you for your thoughts about how it is that nurses like yourself learn to care for the spiritual needs of other people." The object was to attain thick or dense descriptive data (Morse & Field, 1995) to be used in the analysis process. The interviews lasted between one and two hours and occurred in a private location or over the phone.

The audiotapes were transcribed verbatim by a professional transcriptionist as soon after the interview as possible. Once the raw data were received, I "cleaned" the data, checking for accuracy, italicizing words emphasized by the participant, and changing any potentially identifying information. For data management I used several functions embedded in the *Microsoft Word Professional XP* word processing program. I created separate electronic folders for each stage of the research process that included documents, memos, raw data, open coding, and theoretical coding. Within these folders were other folders and files that grouped relevant data together in various ways.

Once I had cleaned a transcript, it was ready for open coding. First, I reviewed the whole transcript, highlighting and bolding key words and phrases. Then, proceeding line by line and using Word's Comments function, I inserted coding comments that appeared in the right-hand margin. As I worked on a transcript, I always kept a memo file open to record notes for analysis as they occurred. As well, I used the Footnote function to record questions and other analytical and conceptual thoughts. Sometimes after reviewing a transcript, in order to capture the essence of an interview, I synthesized and retold the participant's storyline in my words. Once I had electronically coded the data, I made a hard copy and studied the manuscript, making more handwritten analytical notes and using color-coded *Post-It* labels to group fragments of data into substantive categories. At this stage I usually incorporated a session of quiet reflection or talked through my findings with friends. Then I opened all relevant electronic files and sorted the fragments into the appropriate categories. Often, pieces of data would fit into more than one category, showing overlap, linkages, and the rich complexity of the participants' experiences. I constantly compared data amidst and between transcripts for ongoing coding and concept formation, development, modification, and integration. Again I coded, analyzed, and resorted the data that I had placed in each of the original substantive categories into emerging analytical properties.

As expected, very quickly, relevant issues and processes became evident and collection strategies evolved (Glaser, 1978). Resulting from the coded findings that answered questions such as what kind of events were at issue, what they meant, and how they were constructed, I strategically selected participants to further inform those specific analytic codes. For instance, the influence of Christian religious teachings on nurses' ability to learn and practice spiritual care emerged as one of the initial substantive categories. To discover the relevance, scope, and depth of this category, I sought participants through subsequent theoretical sampling who described themselves as nonreligious or from faith traditions other than Christianity. As well, I recruited a pastoral care professional to compare similarities and differences between how nurses learn and practice spiritual care with those of health professionals who specialize in spiritual care.

After the interviews, I wrote field notes that objectively described the setting and context, as well as my subjective thoughts and responses to the interview. I kept a journal with me at all times to record spontaneous reflections and memos for ongoing analytical contemplation and audit accountability. Similarly, to track and synthesize the analysis, I made chronologically ordered and regular electronic entries in a "Memos" file. I constantly compared all data, and, in order to avoid theoretical confusion, I refrained from gathering excessive data without completing the coding and analysis of the existing data (Glaser, 1978).

The essential aim of data analysis is to discover a core variable—in this case, "connection"—that is characterized by its recurrent, central, detailed, and intertwined properties. I conducted the data analysis by using four types of coding: open, theoretical, constant comparative, and selective (Glaser, 1992). Consistent with Glaser's (1978) guidelines, I coded by asking general questions of the data, analyzing line by line, constructing interpretive memos, and refraining from making preconceived assumptions based on demographic information such as age, gender, education, ethnicity, or religious persuasion. As well, to avoid preconception, I conscientiously distanced myself from the information arising from the preparatory literature review and deliberately refrained from searching the literature again until this strategy was warranted for the purpose of theoretical sampling.

Open coding consisted of an interconnected analytic process of deconstructing, examining, comparing, conceptualizing, and categorizing data. From the data arising from the first three interviews, I first constructed rough substantive categories; for example, connection, needs, knowing ways, religion, God's work, and nursing. It was not enough to simply label or open code; I had to conceptualize the emerging theory from the data. This occurred through a process of constant comparison, sorting and resorting of new data into substantive categories, confirming the core variable, and, finally, reconceptualizing and resorting data into four interwoven theoretical categories and their properties.

Throughout the analytic process I repeatedly contemplated and refined ideas that addressed the following queries:

> What is this data a study of? . . . What category or property of a category, or what part of the emerging theory, does this incident indicate? . . . What is actually happening in the data? . . . What is the basic social psychological problem(s) (BSPP) faced by the participants? . . . What is the BSPP or social structural process that processes the problem to make life viable? . . . [and] What accounts for the basic problem and process? (Glaser, 1978, p. 56)

Along with theoretical coding of the data, I also documented, in the form of memos, ideas that occurred during coding. Separate from but parallel to the data-coding procedure, theoretical memos provided the bases for writing up ideas about codes and their relationships in the process of deriving the theory. Through memoing I also compared the data with my experiential knowledge. Glaser's (1978) rules for theoretical memoing suggest that it be focused on concepts and not people, document free-flowing ideas, and not be constrained by attending to an elaborate, logically ordered organizational system. For example, while memoing after one research team meeting, I realized that we had slid towards trying to design the process of learning instead of deriving it from the data. This recognition led me directly back to deducing properties through constant comparison. Through being flexible, yet conscientiously focused on the data, I found that the memoing strategy fostered theory development and modifications. It ensured that my interpretation remained as true as possible to what was actually happening in the data.

Theoretical coding fostered the conceptual relationship between categories and their properties. At the point where a core variable was determined, I ceased open coding and replaced it with selective coding, which entailed delimiting the coding process to the variables significantly related to the core variable. The criteria for the core variable were that it reoccurred frequently, was central and connected to all categories, and had "clear and grabbing implication for formal theory" (Glaser, 1978, p. 95).

Once the core variable emerged and the theoretical categories and their properties became evident, an examination of relevant literature helped to place the emerging theory in relation to other empirical information. However, the purpose of reviewing relevant literature was not to prove or disprove hypotheses, the emerging theory, or other theories existing in the literature, but rather to place, extend, or broaden theoretical concepts and propositions (Glaser, 1978, 1992). Comparisons with extant literature generated ongoing analysis and contributed to theory modification and refinement. As will be demonstrated later, the strategy created an emergent fit between theories, making the emerging theory well integrated with others and more widely applicable (Wuest, 2000).

While consistently scrutinizing for bias, I stepped back and critically analyzed situations, obtained valid and reliable data, and thought openly and abstractly. Thus, as the analytic instrument, I interpreted data with both theoretical and social sensitivity (Glaser, 1978). This process continued until I reached the point of conceptual saturation, which meant that no new data emerged, all clues had been investigated, and connections between categories had been fully revealed and authenticated (Mayan, 2001). Through the process of data collection and data analysis, I interpreted the experience of nurses as it emerged from their own detailed accounts. I then wrote a collective storyline interpretation and sent it to the participants for feedback on how well it fit with their experiences. Finally, I formulated a grounded theory of "connecting spiritually" that explained the basic social psychological process that practicing nurses use to learn to care for the spiritual needs of others.

Rigor

Because the research instrument was a person, the potential existed for personal assumptions and bias to influence the interpretive process. Accordingly, I needed to account for major philosophical and experiential influences in my personal life. Prior to beginning the research, I acknowledged a personal orientation towards Western Judeo Christian theistic beliefs. In addition, concurrent with being socialized to the profession of nursing, I acknowledged adopting a spiritual blueprint for life from the teachings of the Baha'i faith. Consistent with one of the tenets of this pluralist belief system, people are discouraged from blindly accepting the views of others in favor of independently investigating "truth." In keeping with the personally enabling principles found in the Baha'i faith, my nursing epistemology and ontology leaned towards a transpersonal description of human caring (Watson, 1988, 1999) in which a nurse-helper co-creates health with the client-helpee. Throughout the research process I needed to keep in mind that my personal beliefs might affect the analysis. In previous investigations I had demonstrated an ability to contain personal beliefs, remain open, and actively pursue and contemplate alternative opinions from others. After one interview I found myself feeling perturbed by the participant's opinion regarding the exclusive moral authority of a particular Christian sect. I dealt with this through journaling, deep contemplation of the meaning behind the comment, careful inter-comparison and scrutiny within the transcript, memoing, and consulting an expert. Although I acknowledged being influenced personally by religious and nursing theory and being familiar with relevant literature, this study was not contingent on any previously identified theoretical framework. Guarding against preconceived notions, I remained responsive to the complexity of emerging information yielded from the data through a process of constant comparison.

To ensure that the study produced trustworthy, reliable, and valid findings and to prevent error, I used a number of strategies for rigor (Morse & Field, 1995). First, I systematically ordered and dated all interview transcripts, field notes, memos, and journal entries. The journal annotations tracked changes and rationale for any adaptations in methodological approach, such as the data-driven refinement of the interview questions. To help scrutinize for potential bias, I also documented in the journal my subjective interpretations. By conscientiously examining my own biases, consulting with my supervisor and other research peers, and focusing on and continuously rechecking the data, my interpretation remained true to the perspective of the nurses (Morse & Field, 1995).

In terms of facilitating internal validity, I selected participants to review the emerging theory for fit between the meaning described in the data and my interpretation. To guard against threats to external validity, I ensured that I spent enough time in the field exploring patterns of "actions, events, communication, and other relevant contextual and environmental factors" (Morse & Field, 1995, p. 145) to fully saturate the categories. In discussion with my supervisory committee, we decided that the categories were saturated.

Finally, this grounded theory met Glaser's (1992) criteria for evaluating good science, including the qualities of "fit, work, relevance, and modifiability" (p. 15). Reliability and validity were achieved by discovering a diverse, parsimonious, conceptual, and true-to-the-data grounded theory (Wilson & Hutchinson, 1996) that can be used by nurses, educators, students, and the public to better understand how these registered nurses came to understand spirituality, spiritual needs, and the practice of spiritual care.

Ethics

The proposal for this study into the ways, means, and process that registered nurses use to acquire knowledge for spiritual care was approved by the Health Research Ethics Board at the University of Alberta. As well, contingent upon ethical approval, permission to recruit registered nurses was received from the Northern Alberta Clinical Trials and Research Center and the Caritas Health Group Research Steering Committee. This process ensured that the design included satisfactory measures to protect human subjects from any potential adverse affects.

Ethical considerations were premised on the principles of justice, beneficence, a respect for participants' human rights (Munhall, 2001), and an earned mutual trust. I assumed that the participants contributed what they believed to be accurate depictions of events (Glaser, 1992) related to acquiring knowledge for spiritual care.

I protected the anonymity of the participants by keeping consent forms and demographic information in locked filing cabinets separate from the audiotapes and transcriptions. Pseudonyms were used on the transcripts, and, as I checked the raw data for accuracy, I disguised all potentially identifying information such as the names of people or specific employers. Although I strove to assure anonymity, portions of the participants' verbatim words needed to be used in writing the findings. Except for small segments of actual data that will appear in future publications, the information was kept confidential (Morse & Filed, 1995). If data are used for secondary analysis after this study is completed, the subsequent study will undergo another ethics review to ensure the proper use of the data.

Information that I provided to the participants for the purpose of obtaining informed consent included the title, purpose, and explanation of the research, as well as the procedures to be followed. I assured the participants that I welcomed questions about the study and that they could choose to withdraw from the study at any time (Morse &

Field, 1995). All communication with the participants was considered part of the study, and I therefore carefully delineated the data included in the study. I discouraged off-the-record comments, and on the one occasion that a participant asked me to stop the tape recorder, I later wrote field notes, although I did not provide details or consider the information in the analysis. To address potential situations of conflict that may have developed during the research process, I decided that the therapeutic imperative of nursing would take precedence over the research imperative. That meant that I would choose to be sensitive to and advocate for the good of the participant over fulfilling the aim to advance nursing knowledge (Munhall, 2001). After one of the interviews it became clear to me that the participant might be recognized by other members of the research team. Because of the sensitive nature of some of the data and to protect the anonymity of the participant, I consulted with the participant and a previously identified external research advisee about how to proceed, and we agreed that other members of the research team would have access to only the fractured data, not the participant's full transcript.

Participation was voluntary, and interviews occurred in private locations at a time that was mutually convenient to the participants and me. I usually conducted the interviews outside of the nurses' routine working hours and did some follow-up interviews over the phone. Prior to arranging the interviews, potential participants received a letter of information (Appendix C), had an opportunity to question me about the project, and then gave voluntary consent (Appendix D).

CHAPTER 4

NURSES LEARNING ABOUT SPIRITUAL CARE: THEIR STORY

In this research I wanted to explore how nurses working in direct clinical practice learned the skills necessary to care for the spiritual needs of others. Through considering my own experience, speaking with nursing colleagues, and reviewing the literature, I knew that a great deal of confusion exists among nurses regarding spirituality, spiritual needs, and the role of nurses in spiritual care. However, in order to discover what was actually happening, I needed to approach this investigation in an open manner, without preconception. In this chapter I will present the collective story of the way that nurses learned to care for spiritual needs, and in chapter 5 I will explicate and discuss the substantive theory that emerged from these findings.

During constant comparative analysis of the data, it became apparent that the study was mainly about "connection" and, in particular, ways of connecting spiritually. Whether the participants spoke from the perspective of how they learned, what they did, or with whom they did it, the issue of connection appeared. Thus "connecting spiritually" emerged as the basic social psychological process that occurs as nurses learn to care for spiritual needs. Four main interrelated categories and their properties contributed to the all-encompassing process of connecting spiritually: learning connection, nurturing connection, needing connection, and living interconnection. Learning connection deals with how nurses learned to connect, whereas nurturing connection demonstrates how nurses actually connected with patients. Needing connection addresses patients' spiritual needs and how they receive spiritual care, and living interconnection approaches the what, how, and why of living and being spiritual. All of the categories overlap to some extent. I will now lay out the categories and properties of this conceptualization using the detailed voices of the participants.

Learning Connection

Beginning to Learn

This investigation into how nurses acquired knowledge for spiritual care began with a backdrop of uncertainty about how readily nurses would volunteer to talk about an area that has been traditionally associated with religion and often avoided. However, from one brief electronic notice, numerous nurses indicated their enthusiastic willingness to share their thoughts. The first interviews began with a very broad question asking for thoughts about spirituality, spiritual care, and how the participants acquired knowledge for spiritual care. These initial participants spent most of their interview time describing spirituality and incidents of spiritual care and less time talking about how they learned to address spiritual needs. After the sixth interview I adjusted the initial question to focus more clearly on the learning aspect of the study. The participants usually began by describing specific experiences, often very personal, that occurred prior to or very early in their nursing careers. These usually detailed descriptions formed the foundation for relating other factors and experiences that accounted for changes in knowledge and practice.

Unaware or Very Cautious

The majority of participants in this study were over 50 years of age and began nursing practice over 20 years ago. Often, especially nearer the beginning of their careers, the participants reported that they were much less conscious of what spiritual needs were and how and when they would address these issues. Dana complained that in the early days there was *"not time at all to spend time—certainly not getting into any spiritual things."* She continued to describe her long-standing inclination towards connecting spiritually: *"I think for me that connection of just people sometimes can be spiritual—if you just find time to talk to someone maybe about their life, about their children, about their family, who they are."* Associating the process of spiritual connection more with a natural trait than a deliberate intervention, she said, *"So some of that would have happened just because I enjoy doing that, but it wasn't from a conscious point of view of spiritual."*

Even when the nurses thought that spiritual needs might be a focus of concern for patients, they approached these issues with caution. Carol admitted, *"Before I was more vague; I would kind of hint at things."* Jane believed that her formal education actually deterred her from meeting spiritual needs *"because there were these big 'Don't talk about God, and don't make them think the way you do.' It was one of those things to be avoided with a ten-foot pole."* She continued:

> *I was pretty insecure even in what I believed and what I felt. And so I had my own fears of, 'What if I get into this discussion and they come up with this really good counter to what I believe? And then I won't know how to respond.' So I think there was a lot of even insecurity on my behalf.*

Carol acknowledged that her reaction might have had more to do with her initial impression that spiritual needs pertained more to religious beliefs and practices than to the broader need to find meaning, purpose, and connectedness.

Many participants had confused spirituality with religion in their early careers. Dana said, *"In my early years I think I thought about religion. . . . I don't think I ever thought about separating the two. It was just all lumped together. As I've gotten older I [pause] see a real difference."* In comparison, one participant who identified herself as *"nonreligious but spiritual"* readily described an innate ability to connect through nursing. Mavis said, *"I think it has always been a part of me, always been there. Recently, some old friends . . . talked about how . . . they always knew that I was going to do it [nursing] because I had this ability to connect."* Even when the nurses were not aware that they were addressing spiritual needs, spiritual care occurred in the context of routine nursing care. Carol explained:

> *Lots of times when I would do a bed bath I'd say, "Oh, tell me about—" . . . Nurses don't realize how much they do that—they talk to people, and they're interacting with them, and they're touching them, and they're making the eye contact. . . . They are connecting soul to soul. I don't think they realize that; we undervalue it.*

Beginning Sources of Knowledge

In the beginning, knowledge for spiritual care arose mainly from childhood family experiences, the work environment, and observations of nursing exemplars. Bea credited much of her early knowledge to her family upbringing:

> *Even prior to going into nursing at age eighteen, I was raised in a home where my parents were Christians. They were very, very instrumental in me considering the spiritual component for my personal life; and the significance of . . . that connection between looking after the body and the mind, but also the spiritual component, as well. So I certainly do have some roots.*

However, not all participants described early childhood experiences as positive. Several related stories of abuse. Learning from spiritual care arose from childhood struggle and parental nurturing. One revealed:

> *Well, to tell you the truth, when I was young I was sexually abused. . . . Now I think I actually am . . . more able to understand. . . . It has given me. . . episodes of depression. Having had those, I think I was . . . a little gentler. . . . It has worked out and served its purpose. . . . There's people . . . who it has helped because I've been there.*

Along with acquiring knowledge and skills to address the spiritual needs of others, Nadine credited the beginning of her own spiritual journey to working with indigenous people at a specialized federal hospital shortly after she graduated from a nurses' training program:

> *A lot of people . . . still followed their own traditional belief systems. And so I learned very quickly, because of the whole atmosphere of the hospital, that respect for other people was a very important part of giving health care. . . . Some things were a very direct learning process; some of them were absorbed from my family. . . . I don't know whether it is because I talked to the patients a lot or I had other nurses who, by their actual actions, showed respect for these individuals. It was just an automatic; it was kind of like learning as a child. It wasn't any formalized learning. It was the whole atmosphere of the place. You would accept people for who and what they are.*

Few participants were able to specify any formal instruction regarding spiritual needs. Ina noted:

> *I don't know that I actually learned it in nursing school. . . . My entire life there was always caring for people. . . . In psychiatric nursing school we may have had a little bit more, . . . but I also think I had a bit to start out with. . . . Then when I came into registered nursing, I noticed that a big difference was being able to talk to people and have some kind of a connection with them. The focus in the degree program was on the technical part and looking at the disease. . . . Really, all they needed was someone to sit down with them, hold their hand, and talk to them. They weren't "The Gallbladder" or "The Tumor."*

Similarly, Lois explained:

> *Nurses don't get training in a formal academic program to take care of the spiritual needs of others. . . . There is such a conscious effort to separate church and state that religion isn't even spoken about as a nurse. . . . Spiritual care can't even be conceived of because there's still a very black and white distinction between "spiritual care" equals "religious behavior" rather than spiritual care being care of the spirit. . . . Many of my nurse colleagues have done it on their own. They've either brought some of their own religious teachings . . . into their care . . . or they've taken the alternative route: . . . mindfulness, . . . therapeutic touch, Reiki, and polarity, that focus on the Chi or the spirit.*

As Lois noted, others derived guidance from Christian religious sources. Some, like Danna and Bea, trained in hospitals run by religious organizations. Dana commented on the privileged role of Catholic students:

> *My training . . . was run by the Sisters. . . . They were* very present *in the hospital and on the wards and ministering the spiritual care. As a student nurse I didn't pay much attention to them, . . . but they were there. . . . We would gather these babies and take them up to be baptized. I don't know whether we ever had mothers' permission. You didn't even think of it then, but certainly that was a spiritual thing. The Catholic girls got to go along. . . . Well, it may be interference too. . . . The spiritual side of nursing was important at that hospital, but I don't ever remember having a class on it. . . . It was part of our environment, I guess. . . . It probably planted the* connection *of spirituality being part of the care that's needed in a hospital.*

In addition to using a textbook titled *The Art, the Science, and the Spirit of Nursing,* Bea recalled, *"Every morning we had to meet down in the School of Nursing, and before we went on the wards, and we sang a hymn and said the Lord's Prayer. So there was that spiritual component."* She could not remember for sure whether the clergy ever talked directly to the students, but asserted, *"There wasn't any speaking in terms of explanations."*

All of the participants linked their early experiences, whether they were perceived as positive or negative, to their growing understanding of spiritual needs. Gail spoke of the influence of the rigid application of religious teachings:

> *I was brought up in a very rigid fundamentalist kind of background. . . . As I've become an adult, I have redefined those things and moved away from that fundamentalism. I have opened it up. . . . The idea of meditation, . . . therapies to help people center themselves was actually considered evil. . . . I have come a long ways from that kind of rigidity to a place of realizing that faith and spirit is . . . something that I need. . . . In my younger years and in my first years as a nurse, I was extremely zealous. . . . I wouldn't be sensitive. . . . I needed . . . to realize that spiritual care encompasses a really broad spectrum, and it isn't about praying this way or saying these words. . . . I know there were many times where I would feel compelled to want to say, "Would you like me to pray for you?" And sometimes they would say yes. Later on I started to alter how I would say that and . . . explore it more. . . . I would say, "What does that faith mean to you? How does that faith help you in this time . . . ?" And it would be more of a conversation. . . . Or even as parting words to say, "I'll keep you prayerfully in my thoughts." . . . I think now that's probably more helpful to people, for them to have an opportunity to maybe reflect on what faith is to them or what prayer is to them. But before, if somebody would have told me they were Muslim or Buddhist or something, I would have felt like, "That's no good. You're going to hell for sure!"*

Unlike the lack of formal instruction that other participants experienced, the youngest participant described a pivotal learning incident that happened during a practicum with a seasoned nurse-preceptor at the beginning of her nursing education. Elaine, who described herself as coming from a Christian fundamentalist upbringing, discovered the importance of walking beside patients in their spiritual journey rather than trying to prescribe a specific remedy:

> *I learned a lot from working with a parish nurse in my first year of nursing. . . . She was very spiritually open herself. She worked in a church, but certainly didn't share all the beliefs that church had and had extra ones. And so it was interesting to see that you don't have to necessarily be a religious person to work as a parish nurse. . . . Sometimes, you meet somebody, . . . and your natural tendency is to want to help them see things your way, to bring their beliefs closer to what their religion's are. I saw the difference. . . . She saw lots of people that were questioning their faith and were looking at different things other than the [denomination's], and she was totally open to that. She had this very pastoral perspective. She wanted to sort of just walk with people on their journey to wherever they were going. And if that meant they ended up a Zen Buddhist, well, good for them. . . . I really learned from that too.*

> *I think I wanted to fix things when I first went into nursing, . . . and not just physiological things, but more mentally, emotionally, and spiritually. I soon realized that's not productive. . . . I'd be walking with someone and not judging them and just being that listening ear for them.*

Referring back to her example of the parish nurse, Elaine continued:

> *She did end up helping people through things and was part of some sort of improvements, . . . but not that she had a plan in mind of what someone should do and was going to get them to do it; . . . [it was] by letting them talk out whatever plan was in their mind.*

Building on stories of experiences that occurred prior to or very early in their careers, the participants proceeded to relate more poignant experiences, from both personal and professional contexts, that led to the acquisition of knowledge for spiritual care. Ina noted, *"A lot of this I have learned through . . . my depth of experiences, . . . the hardships and tragedies."* She felt that her understanding of spiritual needs "*was nurtured by experience.*" However, not all experiences led directly to finding useful ways to assess and address client spiritual needs; certain types of experiences and beliefs sometimes created barriers to learning the knowledge and skills required for appropriate spiritual care.

Barriers to Learning How to Connect for Spiritual Needs

Although all of the participants were able to describe incidents in which they provided spiritual care, some were less aware of the scope of patients' spiritual needs that required nursing attention. A few participants admitted experiencing religion-based conflicts that sometimes became barriers to assisting clients with broader spiritual needs. Lois said:

> *I know some incredibly competent clinicians that would never deny giving nursing care to anybody but who won't talk to people about their spiritual needs if they're of opposite faiths, . . . so that causes some real issues . . . that are religious based. It interferes not only with spiritual care, but with nursing care.*

For example, another participant admitted:

> *I might sound narrow minded, but I believe that the only spirituality that's going to really make the difference is having Christ. These other ones can provide false hope. . . . You don't have to obtain it through works; it's just through faith, . . . believing without even seeing.*

Even though this participant described several incidents in which she had used her particular religious beliefs and practices with patients and families of the same religious persuasion, she was unsure about the efficacy of her spiritual care interventions with patients of another faith tradition. She related how she cared for those of other religious persuasions:

> *I realize that not everybody has the same belief, and I have to say it makes it more challenging. . . . If someone has a different belief, it's almost like I can't exactly identify with where they're at, but yet I still love them, and I'm still open to pray for them. . . . I just supported them; I offered them my time and my resources. . . . I definitely need to respect people where they're at, and I don't want to be overbearing. That's where a lot of the discernment comes in. . . . You don't want to offend anybody and hurt them when they're vulnerable. And so you need to respect them where they're at and still care for them. And I know that they appreciated me just being there.*

Generally, those who developed fixed notions about right and wrong or good and bad experienced difficulty adapting to change. Elaine compared the spiritual well-being of those who embrace the changes of life with those who focus on fault-finding and retribution:

> *I think some people deal with things . . . as something that happens and not threatening or frightening, . . . but they just see it as part of life. They just grow and adapt to whatever that change is. That would be something I would consider to be spiritually healthy or spiritually mature. And then there's people that deal with things when they . . . perceive it as some form of persecution where something is unfair, whether it's God or whether it's family or life or whatever, and they resist changing . . . their habits, . . . their attitudes. They often have fear and anxiety or anger or resentment. . . . That's a hard way to live your life; it's a form of suffering, and maybe less spiritually mature or in a different level.*

Changing: Properties of the Process

The participants described a range of changes in their knowledge and practice related to caring for clients' spiritual needs. Some of the factors that accounted for change included (a) being open, flexible, and adaptive; (b) struggling; (c) taking or receiving care; (d) taking or receiving instruction; (e) experiencing mystical events; (f) observing; (g) reflecting and contemplating; (h) testing spiritual care; and (i) learning in pivotal experiential events.

Being Open, Flexible, and Adaptive

Prominent in the data was the fundamental notion of being open to finding lessons in experiences encountered in both professional and personal circumstances. Part of being open necessitated the ability to consider, adapt, and consolidate new information through being flexible. Without openness and flexibility, some participants had difficulty identifying indicators of spiritual need, let alone caring for the spiritual needs of their clients. Elaine described learning to be open and to consider the views of others when she attended university:

> *When I was younger, because I was raised in a Protestant Christian evangelical environment, . . . I had a much narrower view of spirituality—. . . narrow meaning I wouldn't be as accepting of other forms, . . . Catholicism, Hinduism, Buddhism, Islam, just to name a few. And then as I sort of grew up, went to university, I was exposed to different people, and then I became more open to people's differing belief systems. . . . A lot of my beliefs have become less concrete, and I'm less sure about things. . . . That makes me more open to other people's beliefs and ways of seeing things, and almost more open to learning from them.*

During an illness Gail learned openness from the experience of being cared for by nurses. Being extremely disillusioned with the unsupportive suggestions of some of her fundamentalist religious friends, she described the unexpected effect of the nurses' encouragement not to give up on her religion, but to consider broader notions of God and religion. She said that it was

> *one of the most enriching things of my life because I found that God was in all sorts of places. And I think that discovery and that opening up of myself has helped me to be a better nurse, . . . and that has become a very liberating thing for me.*

Bea and Fran also stressed the importance of being open to listening to patients' concerns and helping them to explore their issues. Fran said, *"If the nurse is open minded . . . and able to receive, then the client is able to expand and explore. That helps them with their spiritual needs."* Some participants, especially earlier in their careers, complained that they were of the impression that talking about religious concerns was either too private or taboo for nursing practice. In such cases the nurses were not open to addressing manifest spiritual needs.

Thus, being open to helping clients explore issues created change and fostered learning in these nurses. Also, manifesting an open, inquiring, flexible, and adaptive attitude carried over to the acquisition of knowledge for spiritual care that arose from personal events. With openness, the participants struggled through and learned from diverse personal and professional experiences.

Struggling

Most participants described specific experiences that engendered a sense of struggle. This process of grappling with or struggling through difficult issues and circumstances fostered change in knowledge and practice. For example, after questions about the nature of her practice, one participant revealed that much of her knowledge for spiritual care arose from her recurrent struggle with the effects of a mood disorder. She said, *"The other big thing that has influenced me has been my own struggle, . . . because I became aware of what didn't help and what did."* Likewise, Kate detailed the steps for struggling through and testing decisions and actions:

> *It's the school of hard knocks. You learn that through life: . . . "Oh, that doesn't work; that hurts if you bump into that wall. So this feels better if I turn right over here, so why does that feel better? What gives me energy? . . . And how do I want to be in this life?" You learn that just by going through life.*

For several participants, part of struggling occurred in the context of receiving spiritual care.

Receiving/Taking/Choosing Care

The experience of connecting with, passively receiving, and actively taking care from other nurses, along with conscientiously processing the effects of that kind of care, contributed to how many participants learned to care for spiritual needs. Continuing with her story, Gail explained:

> *A lot of things changed through my own life experiences. I ended up . . . being a patient and . . . found myself . . . going through my own spiritual crisis. All of a sudden I didn't have all the answers. They just weren't working. That's where . . . the change came in. I had to really struggle and decide, Was this for real? Did I really believe this? I went through a lot of soul searching and . . . sense of abandonment with God.*

Gail chose to engage with the spiritually caring connection offered by nurses: "*I found the most help in people who were not identifying themselves as a Christian. And yet these people were certainly displaying what I knew as real Christian qualities: acceptance, kindness, patience, understanding, empathy, support, not judging you.*" Gail associated the care given to her by the nurses with the attributes of Christian teachings. By struggling through her illness experience with the professional assistance of nurses, Gail resolved her spiritual needs and learned how to better care for the spiritual needs of her future clients.

Taking/Receiving Instruction

Major sources of guidance that informed the participants on how to care for spiritual needs came from three broad areas: formal education, role models, and faith traditions. Surprisingly, few participants described incidents of direct instruction from formal learning environments. However, many examples of role modeling, including what occurred in the context of receiving nursing care, were evident in the data. Some role models were professional colleagues, but many lessons for practicing spiritual care came from patients and families. Most participants also identified guidance from various religious faith traditions as another significant factor that accounted for the change in their knowledge and skills.

Only one participant, who had entered nursing more recently at the master's level of education, described experiencing specific instruction related to addressing spiritual needs. Lois said, *"The nursing faculty had committed to teaching us Marge Gordon's functional health patterns for assessment, . . . and doing a spiritual assessment is one of those. . . . In my formal education I . . . did a lot with nursing care plans [using] spiritual distress."* Along with guidance from Carpenito's classic work on nursing diagnoses "*at the bedside,*" Lois linked learning about patients' spiritual needs with learning how to meet her own spiritual needs: "*finding ways to address people's spiritual needs at the same time that I was doing this personal exploration into how do I meet those needs myself.*" Other participants explained that knowledge for spiritual care in their formal education occurred more often in the context of learning about culture. Elaine, a recent baccalaureate graduate, explained that

> *a lot of reading that I did as part of my nursing training in university was looking at cultural nursing or . . . interacting with people. . . . That often led to discussions about different ways of being spiritual, or . . . religious, and . . . ways of viewing life and coping.*

Like Lois, Elaine revealed that the experience of exploring how culture, spirituality, and religion influenced health *"helped to open my mind."* Elaine also credited her development of knowledge and appreciation for different beliefs and response to care to a specific type of learning pedagogy. She continued:

> *In some ways people have a continuum of responses and have grown up being taught and believing something probably very different from what I have. . . . When I was in school, we were using that context-based learning system. . . . A lot of group discussion . . . made me see how different people were.*

Like most of the participants who had graduated from diploma programs many years ago, Carol said, *"There wasn't any specific education in the nursing program I did per se."* She added, *"It was being aware of different culture, but not religion or not spirituality."* Carol, in particular, focused on the importance of understanding cultural factors when addressing spiritual needs:

> *It's really important to . . . understand different cultures. That needs to be brought into spirituality as well. . . . I need to know how to interact, how they relate in their community, what's important in the hierarchy of their family, or what traditions are important to them.*

In addition to their initial formal education, several participants mentioned other continuous education initiatives that were pivotal to their development of knowledge for spiritual care. Dana spoke of how she learned to appreciate the importance of finding meaning and purpose:

> *Long ago I went to a really great workshop . . . talking about changing habits and lifestyles. . . . I always think the axle that turns the wheel was the meaning and purpose of life. . . . The next layers . . . were kind of things that you valued. . . . I've used that often. . . . It really helped me. . . . It became part of how I think. . . . The meaning and purpose . . . turns everything. . . . I think that spirituality is a part of that, for sure.*

Although Fran credited most of her knowledge for spiritual care to sources outside of formal nursing education, she described one example of continuing education that was key to her coming to understand that spiritual care is part of nursing:

> *I . . . was accepted to take parish nursing, which was excellent because that's where I realized caring for people in the hospital is not just physical; it's mental, emotional, spiritual. . . . So I did the course and the practicum, and then I realized . . . I wanted to go back into nursing. . . . I could see people differently, see patients differently.*

Other participants attributed the development of knowledge for spiritual care to the influence of friends and colleagues from other helping disciplines. Dana explained:

> *I was exposed to such good and valuable opportunities to learn, valuable conversations and co-workers, . . . which I think broadened my thoughts. . . . Connections with people have helped.. You have discussions, and you grow from those kinds of things.*

Ann said, *"There is something different about those chaplains. . . . They're really there. It's the difference. They are present and listening."* Moreover, Carol, Dana, and Ina described sorting through and learning about aspects of spirituality from their clients and families. Dana summed it up by describing how satisfying it was *"seeing the families and getting a hug."* She added, *"We often talk about what they taught us."*

Along with informal sources of knowledge, other participants noted the importance of religious sources. Fran in particular remarked:

> *I haven't gotten that much knowledge from nursing. I got it more from the outside, like Bible study, . . . from my counselor and my pastor and just associating with Christians . We talk about instances that can encourage other staff. We actually pray for each other.*

The first eight participants in the study attributed much of their knowledge for spiritual care to Christian religious sources. One even believed that the only valid source of knowledge for spiritual care is the Bible. To explore the significance of Christian religious teachings in comparison to those of other faith traditions and ways of knowing, I recruited participants who drew spiritual guidance from sources other than Christianity. One described herself as being spiritually connected without ever having a religious background. Another answered my advertisement and offered to participate *"to educate everyone on what it is to be Wicca."* All participants, regardless of their identifiable religious beliefs, described similar processes to acquiring knowledge for spiritual care. Guidance from faith traditions was important to most. From a Wicca perspective, Nadine and Kate explained that people had to be responsible and accountable for their actions. Kate added:

> *If I can be . . . in tune with who I am as a spiritual being, then that changes me, and anything that changes me necessarily changes all those who are near me . . . because it's all energy. My energy affects your energy; your energy affects my energy.*

Nadine explained, *"In my belief system it says 'Do what you will, but harm none' and 'Whatever you send out comes back threefold."* Ethics similar to the Golden Rule that are evident in all faith traditions guided the development of practice for spiritual care.

Sometimes when conflict between partners in heath care (including professionals, patients, and families) presented ethical dilemmas, the nurses sought consultation from religious experts. Dana reported, *"We have a Muslim man who . . . said, 'Help me to die,' and his wife intervened very quickly and said, 'Our religion doesn't allow that.' So for me then, this was a whole new learning."* Dana described the process of *"finding an advisor, someone from that religion, talking to them, and helping to teach us about it."*

In addition to drawing on the guidance of religious experts and Scripture, Ann attributed much of her patient-care success, especially in situations of uncertainty, to direct connection with God for Divine intervention: *"If I said or did something right, it was not me that knew to do that. I would say . . . my only part in it was giving it over to God."* In this way Ann learned to be a conduit for mystical healing.

Mystical Intuition

Another factor that influenced how these nurses learned to care for spiritual needs pertained to a number of mystical experiences such as Ann's. By *mystical* I mean phenomena that may not be perceived through physical human senses such as sight and hearing. The participants credited some of this knowledge to other worldly forces. For instance, Fran noted that the Divine opens people to knowledge: *"People do have revelations. . . . It's almost like they have an insight into something that they've never seen before. Their eyes are open, their ears are open, and it's almost like God opens them."* Carol described gleaning knowledge from intuition. She questioned its source but not its efficacy for nursing care:

> *I don't know if you can learn intuition. . . . I just know at a gut level that a patient is deteriorating. . . . I think lots of nurses have that, and to me that's another part of spirituality. . . . It's that little voice . . . that says, "Go back." I don't know if that's God that is giving you that little voice. . . . It's intuitive and that telepathic kind of thing that happens between people that leads me to ask the next question.*

Kate asserted that one way to gain knowledge for spiritual care is to ask, "*What's your intuition say?*" Calling this her "*wise woman*" and admitting that she usually experienced trouble if she ignored this kind of information, Kate explained:

> *That's where your spirit is speaking to you if you listen. . . . When I intuit something, I don't have past knowledge and experience about that. I walk into a client's room knowing there's something. . . . I know that because I open my spirit to listening to what their spirit is telling me.*

Moreover, Kate identified certain conditions that contribute to intuitive knowledge: *"Your intuition will flourish if you're feeling safe and if you're feeling confident and if you're feeling there's space for that. Then you will open up and you will listen."*

Like Carol and Kate, several others noted times when they had perceived guidance from the beyond. Some came in the form of dreams. Ann described having prophetic dreams about patients, and Dana added, *"Sometimes other people that you've* *connected with in your life . . . come into your mind to help you to get the right kind of nursing connection with this next challenge."* Intuitive mystical knowledge would have been fruitless if nurses had not observed, paid careful attention to, considered the relevance of, and adjusted their practice to test the significance.

Observing

Through opening and struggling with experiences such as taking spiritual care, receiving instruction, and perceiving mystical intuition, the participants acquired the fuel to process the information and learn. Other factors that accounted for the change process were connecting careful observation, reflection, contemplation, and testing.

Just as Gail observed and learned from the nurses who had cared for her, several other participants described how observing other nurses helped them to learn ways to address spiritual needs. According to Jane, *"I think a lot of it is learned when you . . . observe how other, more senior nurses work. You sort of watch them."* She described watching a nurse work with a family:

> *She just had a really great way of comforting them and encouraging them. They were very open to discussing more the spiritual end of things. She just had a really good way of bringing it up and developing a really good rapport. . . . It was . . . something that I observed, . . . a good thing for me to see.*

This experience gave Jane "*a little more confidence that if . . . families . . . were kind of floundering and seemed open to discussing, that was okay."* Previously, Jane had avoided those kinds of discussions "*because I think sometimes it's kind of drilled into you, 'Don't share your personal convictions.'"* Thus, observing another nurse contributed to Jane's changing her practice to embrace interventions for spiritual care.

Reflecting/Contemplating

Once a nurse paid attention through observation, reflection and contemplation needed to occur for her to connect the knowledge gleaned from the past with the current experience. Through the process of reflecting and carefully considering implications, the participants discovered meaning from associating the contexts of past and present circumstances. Elaine reflected on the implications of trying to save a physical body regardless of consideration of other aspects of human existence: "*Thinking about the* *meaning of what we're doing, . . . you're really dealing in probably the spiritual.*" Similarly, Fran and Ina explained the process of questioning previous experiences, beliefs, and practices in order to be open enough to learn and apply meaningful knowledge. Fran said, *"I know that not everyone experiences what I've gone through, and I know that how I acquired my knowledge was really deep down looking at my life and seeing the path that I led, and how it's led me to here."* Ina added, *"In the last ten years or so I have . . . more and more questions of 'why.'"* She emphasized that she did not

> *just blindly believe in everything as I was taught as a child. And so now . . . I'm much more curious about other people's belief systems. It helps to explain a lot of things. . . . It's just made me a little bit more open and more able to think more critically for myself.*

Observation, questioning, and careful consideration led to consolidation of new ideas. Once these new ideas were formed, decisions about ways to change practice were developed and tested.

Testing

There were many examples of how the participants tested different nursing interventions to meet spiritual needs. Some believed that knowledge for spiritual care arose more from the doing aspect of nursing than the reflective aspect. Kate said, *"It's not an intellectual thing; it's a doing, being, growing, trying to live a conscious life."* Others, such as Helen, spent less time contemplating and more effort trying to practice in ways guided by the Golden Rule. She tested knowledge that she had gleaned from her church:

> *I thought, What would my family want? . . . Simplest things . . . make the difference. . . . Massaging a person's feet, . . . they remember that. . . . Nursing courses don't teach you that. . . . Sometimes I think that if we would . . . do more listening than talking, we might get more ahead with our patient. . . . Let's get a little more human, . . . kinder . . . words, just treat people how you want to be treated.*

Nadine told an incredible story of how nurses carefully considered the meaning behind the unexpected death rates amongst postsurgical Inuit elders. Observation, reflection, and consultation with an expert (an anthropologist) led to the nurses' developing and testing a culture-specific nursing strategy. Using story, Nadine intervened to teach and ultimately facilitate a change in beliefs that resulted in decreased mortality rates. She explained:

> *We were discussing the fact that a lot of the elderly Inuit people . . . would be fine post-op, . . . and within two or three hours they'd have massive MIs*[1] *and die. And they had no idea why. . . . In the Shamanistic belief, if you have a major pain, you're going to die. . . . It's something that is so serious, . . . the Shaman can't barter. He can't go into the spirit world. He can't correct what is wrong. If it's a psychological thing he might be able to, but if you've got a ruptured appendix, you're going to die. . . . So he would say, "A very powerful Shaman has put a [curse] on you. You're going to die, and there's nothing I can do."*
>
> *So we would include, "The white Shamans work different . . . than your Shamans. Our Shamans like to be able to prove that you're really, really strong, and so we give you a pain afterwards. And that's to test you. If we test you and you're strong, you will live and you'll be okay." The cardiac arrest quit when we included that as part of our pre-op teaching.*

From the testing and success of this unique story-teaching strategy, Nadine went on to develop similar strategies using imagery to foster the acquisition of meaning related to healing events with future clients.

Pivotal Experiential Learning Pieces

Over and over again the participants told stories of specific experiences that became pivotal in their growing ability to address the spiritual needs of their patients. Carol said:

> *I don't think you can necessarily learn it in a book. Part of this spiritual growth for me is living life, having life experience. Having different losses . . . that I've had to process. Having good things too: having kids and having relationships.*

It seemed as though learning was ratcheted forward in pivotal learning pieces. Some experiences occurred in professional contexts, and others were more personal. According to one participant:

> *There was a turning point in my life. . . . I remember trying to [hurt myself]. All of a sudden I just sat back, and there was this light in the bathroom that shone through. . . . I started to cry. I had this flash through my mind, thinking, It'd be*

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[1] Myocardial infarction.

> *easier just to end it. And then all of a sudden I thought, No. I just looked up and I said, "God, You have to help me." This peace, incredible peace came into my heart that made me realize it's going to be okay. . . . And so that was basically the breaking point. . . . I had never experienced it before, even through going to church all those years. And so that's when I made the step.*

Carol described a moment of connection between her, her patient, and the Divine, which opened her to anticipating opportunities for mystical healing in her future practice:

> *He was on the verge of dying, and I was transfusing platelets, hanging on; and I just put my hand on his shoulder, and it felt like there was an* energy*. . . . He did a turnaround within about a week. It was pretty amazing. . . . I was kind of praying—not really praying, but just talking to the Creator and just—. . . kind of trying to keep myself open.*

Thus through opening, struggling, taking and receiving care, observing, contemplating, and testing, these nurses connected pivotal learning experiences that progressively changed into a mosaic of spiritual care knowledge and practice.

Changes in Knowledge

Changes in both knowledge and practice occurred as the nurses developed skills to attend to their clients' spiritual needs. Gail optimistically commented, *"If you are going through something, you might as well get your money's worth [laughs] and learn as much as you can from it."* Evidence of major changes in knowledge manifested in the form of new beliefs and the increased ability to perceive spiritual phenomena.

Beliefs. One kind of change that most participants noted pertained to beliefs about the connection between spirituality and health. As noted earlier, in the beginning of their nursing careers most participants confused spiritual needs with religion. However, they all to some extent came to understand that spiritual needs pertain to more than just those associated with religion. Although religious beliefs are important factors to assess, spiritual needs encompass a broader aspect of the human health experience. In addition to collective sources of moral guidance and community support experienced through association with specific faith traditions, spiritual needs include ways of discovering and connecting personal meaning to health events. Some participants were more cognizant of activities to address spiritual needs than others. All participants, whether they recognized it or not, described the need for connection. Knowledge for spiritual connection refers to the quality of an integrated self, the cohesiveness with others, and interrelatedness with the Mystical Beyond. Acquisition of a broader notion of spirituality embraces the need to make sense of and find meaning in health-related events. In the beginning of Elaine's career, she became very distraught in witnessing the struggle of her patients. Through experience, she changed her outlook and learned to "*connect loss with something that people have to deal with.*" She explained, "*I just equate it more with a spiritual experience or a growth experience . . . . If you lose something it gives meaning, but it can cause distress, . . . depending on how you choose to deal with it.*" Elaine no longer believed that she was not providing good care when her patients were distressed. She came to understand that struggle is an important process in order to grow spiritually.

Dana, like several others, depicted a time in her career when she questioned the fairness of tragic circumstances for a young patient. To grapple with these kinds of doubts, several participants described working through their beliefs about Divine justice and human purpose. Carol explained:

> *A lot of people . . . have a belief in a punishing God—a God that's on a smite button. Like the man who's . . . chronically suicidal. He has this belief system that God is out to get him. . . . God doesn't think you're good or bad; God just accepts. . . . I sort of adopted the belief that a lot of what happens to us is what we choose to believe.*

Like Carol, others changed or adjusted their beliefs to accommodate the importance of distress.

Beliefs were strong motivators for offering spiritual support. Some participants were of the opinion that "*nurses that are more in tune with their own spirituality are able to help patients with their spirituality or their spiritual needs.*" For some, personal beliefs stemmed more from religious teachings. Others suggested that, although a nurse did not have to be religious in order to care for spiritual needs, he or she needed to be open to listening to and working with the client without preconceived judgment. Carol revealed how she learned to tap into Divine sources of healing:

> *Meditation is really important for me. . . . I have a room in my home that I've dedicated for that. . . . It gives me the energy to do what I do. If I connect with my higher power, . . . I get the energy . . . and it comes through me; . . . I'm more of a conduit.*

Similarly, speaking of her strong connection with the guiding wisdom of God, Ann described how her beliefs and practices had changed over the years so that *"I think I've got to the point where I do all my nursing like that; . . . I never go there alone."* She explained that she had prayed for God to assist her to help a patient with whom she was struggling:

> *She didn't change, I don't think, but the way I looked at her completely changed. . . . Basically I just said, "I can't do this, I can't; I can't love this lady. You're going to have to love her through me. . . ." I saw that lady completely different; I saw her as God, in her, as the person I was serving, which was ultimately God, personified.*

For some participants, as changes in their beliefs occurred, so did their ability to perceive spiritual phenomena and events.

Ability to perceive spiritual phenomena/events. Most participants were unable to think of times when had they observed clients experiencing mystical phenomena such as premonitions, out-of-body experiences, possession states, or Divine intervention. However, a few noted their growing ability to perceive such important, albeit less usual, spiritual events. Nadine spoke of a time in her career when she had witnessed a young patient who had been *"cursed"* by a shaman and as a result died:

> *To be honest with you, at that point in my own belief system I was really not prepared to accept what I saw, and so I just blanked it out. Now days . . . I've finally come to the realization that I'm far more aware of energy, . . . of spirit . . . Having seen individuals who had such strong beliefs, cursed or something, . . . has really strongly influenced me. I perceive energies, I perceive spirit. . . . I think that's why my particular belief is now that I accept that there is such a thing as spirit, I accept the fact that there are various energies that could be either positive energies or negative energies.*

This demonstrates, through openness and change in beliefs, the development of an ability to perceive and thus assess the effect of spiritual forces. Similarly, Elaine, who is still near the beginning of her career, acknowledged a change in her ability to perceive spirit: *"As I evolved, my ability to perceive people as spiritual beings also evolved."*

Changes in Practice

Just as changes in knowledge led to changes in beliefs, changes in beliefs and understanding contributed to new ways of practicing spiritual care. Speaking of witnessing the struggles of her patients, Ina said:

> *It's kind of like a wake-up call. . . . It inspires me to be a better person, . . . to spur me on to have more compassion and more patience and spend more time with people and listen to them more and let them talk.*

She noted her responsibility to adjust her practice to address spiritual needs: "*I can change how I interact and what I do with this person. . . . They need to feel that they're useful, loved, and cared for.*"

Like Ina, Kate detailed the process of careful reflection and evaluation of patients' responses to nursing actions in order to develop more useful ways of practice:

> *You have to look at yourself, say, What did I do to bring that on? What part did I play? I must have played a part. . . . And then maybe I can change it, because the only person I can change in life is me. . . . If I change me and I start reacting to you differently, you're going to . . . change your behavior. . . . Until you get the lesson, . . . sometimes things happen to you over and over again. You say, Why? What do I need to learn here? . . . So if I'm always walking into a patient's room and they're always bristling at me, what's the constant here? It's me. How am I greeting that patient? Maybe I'm doing something that is pushing their buttons, making them react to me in a negative way, so I need to look at that. And that's all part . . . of who I am. . . . Spirituality is part of it.*

Carol noted that the knowledge that she gained from a support group led to a change in practice:

> *My practice of spiritual care has changed. I'm more comfortable talking about it, raising issues around spirituality. . . . . I've been in the Twelve Step Program for nine or ten years, and I've done a lot of my own personal growth, and I'm fairly comfortable in my own skin. . . . When we're in that place, we're more able to relate with people.*

Rooted in experiences for acquiring knowledge to meet client spiritual needs, some participants also described a need to protect themselves.

Ability to protect self from "spiritual" harm. Although the participants were generally not able to recognize spiritual phenomena in their clients, many described the need to develop practice strategies to protect themselves from spiritual harm, which means, generally, the adverse effects that these nurses experienced during the course of their helping work. Practice changes usually pertained to different ways of thinking, such as adjusting beliefs, attitudes, or intentions.

In the few years since Elaine had first started practice, she spoke of developing the skill of professional distancing. She described it as *"a healthy change"*:

> *I don't come home feeling as upset and distraught as I did when I started working in care centers. . . . When I started working . . . I came home crying for the first two weeks . . . . I think practicing for a while, I am a bit less sensitive. . . . I don't think I'm hard. I don't think I've lost connection with people and their distress. . . . I'm just maybe a little more professional, more objective.*

Sometimes the participants described feeling drained. Fran noted, *"It's a really hard job at times. It can drain me . . . because I give too much of myself. I perhaps get too involved in their grief and take some on myself."* One strategy that several participants used to deal with the troubling issues encountered in their work was to invoke other-worldly assistance. Fran explained:

> *When I go home, if it's a late shift, I have trouble sleeping. I need to almost set a boundary and give that grief to God. . . . It doesn't always lift right away, but soon after it does. It's almost like mentally I need to say, This isn't for me to carry. I'm not to carry this load. This is for Jesus to carry. He can carry our burdens; make the load light for us. And it lifts.*

Similarly, others described different mystical protectors. Dana said, *"I have an image of my guardian angel. In fact, I think it probably changes. I don't have this visual image, but I have a spiritual feeling. . . . Connected, support, sometimes even assistance."* She noted the gradual evolution of this practice resource: *"I think it always was part of my nursing care, but certainly now more than ever."* Several participants described the use of visual images and thought processes to deal with negativity. Kate said:

> *It's all energy. My energy affects your energy; your energy affects my energy. I have some tools that I can use that I learned . . . to protect me if you have some bad energy coming my way, or . . . I'm feeling really icky that day.*

Nadine explained:

> *If I'm being harmed spiritually, I will put up a shield. It's a thought form, . . . like a veil of like iridescence. I would say, Whatever energies are coming here that are not for my highest good, I want them to go down into Mother Earth and be cleansed.*

Using mental mechanisms, these nurses were able to change their practice in ways that protected them from harm.

From fixing to facilitating. The next change in practice was perhaps the most significant in the way that the nurses adjusted their approach and learned to care for spiritual needs. They learned to connect when they shifted their care expectations and practices from a nurse-centered intent to fix a patient's problem to a client-centered practice of facilitating client exploration and fostering the best quality of life. Ina said:

> *I used to get sort of uptight: Where's the problem? What are we going to do? How are we going to fix it? The years of experience have kind of settled in. . . . I don't need to fix everything, and I don't need to have an answer, but I can just listen. . . . Some people will be on a journey that is just meant to go in the toilet basically. But you can still be there with them and help them, . . . to listen to them or to offer them whatever might be helpful at that moment. You may not be able to change them because they're on this journey.*

The story of the youngest participant was a prime example of a progression from a practice of trying to fix to one of learning to facilitate. Elaine explained that at age 24 her understanding of spirituality and spiritual care evolved. Coming from an evangelical Christian upbringing, she entered nursing with a more narrow view of spirituality than the one she currently understood. Her initial notion of spirituality manifested as a result of her inability to accept other forms of Christian belief and non-Christian faith traditions. As well, at the beginning of her education, Elaine expected to be able to give patients an answer to their concerns or fix their problem. During university, through exposure to different belief systems, cultures, peers, patient difficulties, and stages of patients' lives, Elaine became more open to many increasingly diverse expressions of spirituality and spiritual need. As a beginning student, she learned from a parish nurse that to practice spiritual care meant to be very pastoral. Through mentoring and receiving spiritual care, Elaine began to recognize that walking with someone, being nonjudgmental, and listening carefully were far more productive than approaching a patient with a preplanned fix or solution. As an undergraduate employee in continuing care, Elaine described feeling depressed and crying over her sense of powerlessness to prevent her residents' humanity from being stripped away. She began to attend to spiritual needs by treating her residents with dignity, calling them by name, respecting personal space, being empathetic, and facilitating conversations about meaning of events/situations. She treated them as she would have wanted to be treated and developed a deep emotional, spiritual, and psychological connection with her clients. After a couple of years of nursing practice, Elaine found herself feeling less personally affected by the distress of her clients. She said she became more professional, more objective, and more open to the unfolding lessons abundant in life's experiences. Instead of meeting her own need to help, she concentrated on attending to the issues and needs identified by clients. She found that her beliefs became less concrete. She was less sure and more open to learning from others, thereby expanding her horizons. She learned to be a little removed from her clients' distress and no longer felt compelled to swoop in and make everything a little better. In her words, Elaine strove to be *"less judgmental, more open, and remember to respect* their *autonomy and not be as vulnerable myself."* Elaine learned to *"be there"* through personal and professional experience.

Range

The data show considerable range in the nurses' ability to learn and practice spiritual care. Some participants focused more on describing how they personally acquired spiritual knowledge than on how they acquired knowledge for spiritual care. At least two participants admitted volunteering to participate in order to convince others of the credibility of their respective faith traditions. Even after the research question was modified to more clearly solicit information about learning to care for spiritual needs, one participant was unable to identify specific examples of client spiritual needs other than the need to have a kind, spiritual nurse. When asked what she meant by showing spirituality without mentioning religious words, she paused and tentatively offered:

> *I'm not sure. . . . I think it's everything. I think it's when you're doing morning care, . . . show kindness or spirituality. . . . If you can feed in a slow, gentle, kind manner, that shows a compassionate nurse. Your tone; . . . I think your actions speak loud. . . . I get my spiritual care by going to church and getting involved in small groups. And then I take from that and apply it to my everyday life. So I'm kind of taking, I guess, responsibility in my own care.*

Although this participant had been practicing for many years, and indeed was able to articulate numerous caring practices that fostered connection, she was not cognizant of assessing specific client spiritual needs. In comparison, in the example above, Elaine, who had been practicing for only two years, identified numerous client-centered spiritual needs and specific creative strategies for addressing those needs. A few practices, as will be more fully described in the Needing Connection section, interfered with spiritual well-being. The data show that these nurses could attend to spiritual needs in different ways with a range of proficiency and effect. The rate of growth in ability to care for spiritual needs varied. Pivotal experiences often enhanced nurses' capacity for spiritual care. Thus, the data show that nurses ranged in their awareness of spiritual care practices from unconscious not-knowing, to deliberate avoidance, to tested efficacious spiritual care interventions. The amount of time that it took to progress towards more efficacious spiritual care practices also varied. The data were insufficient to determine whether changes in the curriculum of formal education in more recent years accounted for the change in ability or capacity to care for spiritual needs. It was clear that registered nurses in direct clinical practice evolved in their ability to care for spiritual needs during their careers. All of the evidence shows that they always made progress in one direction towards implementing knowledge to address spiritual needs. Lois demonstrated the ongoing struggle and continuous learning associated with how to care for spiritual needs:

> *I think my comfort level is in transition. This has troubled me for some time because here I am, I'm a Reiki master. I believe in the stuff. So, because I've seen such great results, I know it makes people feel better. But I haven't taken the next step to teach it. . . . There's something holding me back. . . . There's a part of me that does not want to impose things that I feel are spiritually right. . . . I know there are ways that people can enhance their spiritual health, like giving yourself Reiki or participating in a religious practice. . . . If I starve myself spiritually, I feel that there is something wrong with me. . . . I don't want to say I'm ill; I'm just not healthy. When I focus on attending to practicing with my spiritual interests, which are connecting with the Divine, connecting with other people to everything around you, it makes me personally feel like I am complete; there is nothing missing. . . . For me, connection is the ultimate. . . . So when I think about why I would take the time to learn techniques to bring spiritual nourishment to patients or colleagues or family members, I think for me it's wanting them to have that experience. . . . I don't think everybody knows that they need to be fed spiritually.*

In the Learning Connection section I have shown a part of the basic social psychological process of "connecting spiritually" from the perspective of how nurses learn about connection. The experiences described in this theoretical category include aspects of opening and experiencing, taking and receiving, reflecting and struggling, responding and testing, and being or living connection. The next section details a perspective of connecting spiritually that focuses more on the practice of caring for spiritual needs.

Nurturing Connection

Another part of understanding how nurses learn to care for spiritual needs entails exploring how nurses actualize the practice of spiritual care. As was noted in the previous section, pieces of learning involve observing, considering, testing, and evaluating effective ways to intervene. The participants connected knowledge gleaned through experiences in order to learn. Applying knowledge related to caring for spiritual needs entailed nurturing a therapeutic connection between nurse and client. In this section I first describe the essential nature of nurturing spiritual connection. Then I expand on how therapeutic connection is developed, who nurtures connection, and where and when therapeutic connection occurs. The properties associated with the what, how, who, where, and when of nurturing connection are detailed through the voices of the participants.

Presence: The What of "Nurturing Connection"

To understand what nurturing connection entailed, I not only had to discover the essence of the participants' perspectives, but I also had to consider important factors that illustrate the barriers and boundaries of this theoretical category. The properties within the concept of presence range from not connecting to being client-centered and fully connected.

The Nature of "Nurturing Connection"

When asked for examples of spiritual care, a few participants began by addressing religious concerns. However, in all cases the notion of connecting with clients emerged very quickly. Often shifting from a prescriptive nurse-centered approach to a facilitative client-centered approach, the participants described using a process of careful attention, listening, reflecting, and helping clients to explore issues such as the meaning and purpose of their health/illness experience. In practice, a nurse's focus most often shifted from doing to being with, being there, and being present with the client. Gail explained:

> *Years ago I would have looked at it very black and white. You just do and say this, . . . quote a Scripture here and there, and that would be it. But with my own personal growth, the changing and the growing of my belief, [I found] . . . it encompasses so much more. . . . That whole aspect of being is one of the hardest, but it's one of the most powerful things. It's the* Ministry of Presence. . . . *Those words have stuck with me. . . . Even in a very busy, frustrating day . . . it is valuable. It is being present for them in that moment. Spiritual care or meeting someone's spiritual needs or being open does not always mean that it's a crisis. . . . Connecting with their spirit can be in fun, in joy, in laughter. . . . We're so darned busy, it's very hard to sort of pull it back and say, "I'm going to spend a few minutes here and really connect."*

To facilitate exploration of spiritual concerns, Lois identified the enabling root of nursing care, to nurture. She said, *"This part of nursing I think of as the nurturing part. . . . This puts the C in* care. *That is the foundation of spirituality."* She addressed the need to integrate spiritual care into all nursing practice:

> *Nurturing of spirit is more important to someone's well-being than just caring for the physical body. Someone can be in perfect health and can be . . . spiritually bereft and not be healthy. And someone can be on death's door physically, . . . but be spiritually full and not be suffering.*

In a poignant example of addressing spiritual needs at the same time as providing physical care, Gail illustrated the essential nature of nurturing connection:

> *One of my most vivid memories is just shortly after I graduated. . . . I was in a severe car accident. . . . I had multiple broken bones, . . . but my girlfriend died. Strangely enough, I had a student nurse look after me. I was actually horrified—not that it was a student, but it was a male! And I thought, Oh, my God! I couldn't do a thing for myself. I needed to be catheterized; I was having my period; I thought, Can this get any worse? . . . How am I going to live through this? That young man . . . was phenomenal. He had it. He had it. He had that ability, that extra sense of other stuff happening. He did his care . . .* very *compassionately,* very *respectfully, and made that as easy as possible.* And *he went the extra mile. I had long hair. . . . It was all knotted up with pieces of glass and grime from the highway, and he washed it and combed it all out. . . . I couldn't believe he did that.*
>
> *He finished doing all of this care, and we had just been . . . joking back and forth. . . . I thought, Okay, he's going to go now, and I'll be left alone, and*

> *[whispers] I can have my cry. He finished, and he didn't. [cries] He didn't leave me. All of a sudden, everything was done, and it was just* there. *And he sat down and just* stayed. *I felt ultimately cared for and safe. . . . It's not like I was feeling unsafe in the hospital, but there was so much going on. I was feeling guilty for being alive. [cries] I had a lot of pain, and I wasn't reporting it [cries] because I didn't feel I should.*

This example shows how learning connection is connected to the nursing process of nurturing connection and the patient's need for and action of engaging in or taking the connection. As a patient, Gail risked being hurt, embarrassed, or judged when she chose to take the student nurse's offering of therapeutic connection. She received spiritual care, analyzed its effect, and learned how to nurture connection with her own patients. Gail was amazed at this student's care, and she compared it to an incident in which she did not feel cared for by or connected with nurses:

> *On the other hand, in the same hospital experience I also experienced hearing nurses speaking at the door. I needed to be turned because I couldn't do anything, and . . . hearing them say, "Oh, we'd better all go in there. She's a big one." So in the same place feeling, on one hand, condemnation and on the other hand—care.*

Gail's example showed the often hurtful impact of nurses' performing tasks without sensitive connection to the patient. Mavis described watching another nurse gesturing with her arms to smash away a patient's perception of guardian angels at the foot of her bed as she exclaimed, *"There's nothing there!"* Mavis thought, *"How could you do that? This was so comforting to that woman, and she just hushed them away. Don't do that."* There were many other examples of not connecting and of barriers and boundaries to the nurses' being able to be present with their clients.

Barriers and Boundaries to Presence

Other kinds of barriers to being able to connect therapeutically include an underlying hesitance to assess and address spiritual needs, confusion with personal beliefs, preoccupation with personal circumstance, and fulfilling a religious or personal agenda.

Sometimes even when the nurses tried their best to connect, they became trapped in the patient's emotion and felt helpless. Mavis described an incident of a psychiatric patient who *"loses everything over a twenty-year period [and lamented], "That is what my life has become."* Mavis admitted:

> *I've never felt so helpless as a nurse, that day. I just sat beside him and talked. . . . I don't know if it helped him. We just sat. I had no idea what to do. So that's a case . . . where you don't connect. I felt down in his hole. . . . It looked as hopeless to me as it did to him.*

In this example Mavis became caught in the patient's struggle and had difficulty setting a boundary between his circumstances and hers. Although she sat with him and listened, she was unable to therapeutically connect, disengage from his sense of helplessness, and help him to cope with his situation. Thus, emotional attachment to a client's misery can become a barrier to connecting therapeutically.

Certain personal and professional beliefs create other barriers. Some participants, especially nearer the beginning of their careers, were hesitant about approaching issues of spiritual need, especially if they believed that they had nothing to offer. Other nurses sought patients' permission before assessing spiritual need. Elaine explained:

> *I don't know too many [nurses] that would . . . assess people in the spiritual sense, because what kind of interventions could be set up for them? . . . If you can't do anything about it, then don't assess it. . . . I have to wonder if it even is a nurse's place, . . .* unless *the patient asks.*

The nurses' personal beliefs also affected their ability to address spiritual need. Describing her experience with nurses in an intensive care setting, Ina felt that nurses could *"be there . . . more emotionally . . . than spiritually"* and that when nurses are uncertain of *"what they believe, they can be very supportive . . . on the emotional level, . . . but on the next level down, the spirit level, there can't be a connection."* She added, *"If someone is talking about their relationship with God, . . . there can't be that next level of connection because . . . [the nurse] doesn't understand what [the patient is] talking about."*

Sometimes when nurses have the knowledge and skills to connect therapeutically and intervene with spiritual needs, personal circumstance may interfere with their practice. For instance, Carol discussed a time in her career when she *"had the knowledge"* to address spiritual need but *"was just more closed."* When asked what caused that, she paused, admitted being fearful, and then thoughtfully added, *"I'd say it was my own personal place or space in life, where I was pretty shut down."* After detailing some of her personal struggle, Carol explained its affect on her ability to connect and provide care: *"When I'm shut down that way, I can't share with other people because it's not there to share."* Along with personal issues that interfere with a nurse's ability to connect, other participants described times when they took on the emotions of clients in a personal way. Taking patients' behavior personally leads to nurses' feeling unable to cope and interferes with their ability to be fully present for the good of the client. Kate explained: *"People would be angry and fearful and hurt and scared. . . . After a while you just can't cope with it. You see a lot of nurses just wall off. . . . They're not meeting the spiritual needs of the client because they can't even meet their own."*

Another barrier to a nurse's ability to be present with what is actually happening is having an agenda external to the voiced spiritual needs of the client. Agendas can stem from personal beliefs about what is right or wrong, good or bad, important or not important with regard to a client's situation. The participants who gave examples of having a hidden agenda seemed unaware of the impact of their actions. For example, one participant said, *"There are a lot of people that are . . . deep in that grief and they haven't moved forward at all."* She described a woman who was *"down on God"* because of her suffering. To convince the client of her religious belief, the participant felt compelled to defend God: *"It's hard to try and explain that God allows suffering, but He doesn't always cause it."* Then the participant *"offered to pray"* for the woman. The woman said that she felt better, but, the participant added, *"it doesn't always make a difference right away."* The nurse was not tuned in to what the woman was saying. As a nursing measure she offered to intercede with God, without accounting for the fact that the source of the woman's doubt was God. The woman may have said she felt better to placate the nurse. Then the nurse, likely unconsciously, linked this incident to not achieving immediate results. Interestingly, this participant immediately began to identify other strategies for spiritual care that were very consistent with the ways discussed by other participants for nurturing connection:

> *I think just letting people know that you . . . truly care for them helps to make a difference, spending that extra time and effort with them . . . to really get to know people. I'll sit with them, . . . talk to them, and ask them questions. . . . You get to really know who they were, and it's so amazing.*

It seems as though, without realizing it, she was reminded of more appropriate actions to nurture connection through sitting and listening, spending time, and asking relevant questions.

In another case the participant had a hard time coming to grips with beliefs and practices that were unlike her own. She explained:

> *I have a hard time with Islam. . . . Women are very second class, even though they won't see that. It was difficult. I had to use all of me to be there . . . in, I call it Muslim Land. [laughs] Some of them were . . . difficult and rigid. . . . When we would be talking, I could be more comfortable and let my sense of humor out. . . . They have a wonderful sense of humor, but you have to be able to tap into it as opposed to judging. I'm not judging, although I am a little . . . .*
>
> *So, I would tease them. . . . I would say God-She, and they'd [gasp], "No, Miss, not God-She." . . . And so then I would just put that thought in their little minds, . . . and some of the women would get it . . . a little bit.*

In this case the nurse's secular beliefs and her agenda to convince others not only interfered with her ability to connect, but also contributed to her duress and personal sense of well-being.

Along with following an agenda external to the patient, self-centered behavior also can adversely affect the presence associated with connecting therapeutically. Elaine examined her motives in providing care. She wondered whether some of her intentions were *"a little narcissistic,"* even focused on meeting her needs instead of the client's. She likened it to *"that* helping *personality [where you] just give and give until there's nothing left, . . . or . . . looking for problems where there aren't any."* She contemplated, *"Is it them who want some form of comfort, psychological or spiritual, or is it me who wants to accomplish something? Is it* me *feeling like* I *want to be sensitive, . . . empathetic?"* Elaine agreed that one way to determine whether the nurse is being present is to ask, "Whose needs am I meeting?" This strategy turned a barrier into a boundary in order to stay focused on truly being there for the client.

Other participants learned different strategies to set limits on personal involvement with client issues. Fran said, *"It's a really hard job at times. . . . I find it draining because I perhaps give too much of myself. I get too involved in their grief and take some on myself, ... When I go home, I have trouble sleeping."* To cleanse herself, she said, *"That's where I need to almost set a boundary and give it to God."* Similarly, to connect therapeutically with upset clients and families, Kate suggested, *"Open yourself up to that."* She clarified, *"It's not like you have to jump in. You still need your boundaries . . . and [to] not take it on."* In addition, *"Listen to them and paraphrase it, clarify it and have compassion."* Elaine noted, *"I'll still try to give my attention . . . so that I can find out what* their *issues are and what* they *want to see different. . . . It's a little bit more objective and professional. It's sometimes a little bit more removed."*

With boundaries in place and being fully present with the client, Gail captured what the simple yet profound nature of nurturing connection entails:

> *And you stop and you sort of put your hand on their hand and say, "How are you doing today?" And all of a sudden you get it all. And that's what I think is real spirituality. . . . I think that's part of being sensitive and perceptive and using even that intuition where you just have that sense. You think, I don't have a clue why I should go back and check on that person. And you go, and you find they're sobbing in their bed. It's just then sitting with them. For me, that is the epitome, the highest point of nursing.*
>
> *. . . But at that point they are* really *vulnerable, and it's all right there. . . . I think it's a sacred, holy moment when that happens, because someone is letting you inside to their deepest place. I feel like it is a* huge *privilege to be there. And I think I have learned now over the years that that is really the* only *thing that I need to do, is to be there. I don't need to have the answer; I don't need to solve the problem. I don't even need to ask the question. I just need to* be *there. If they've allowed me to be there, then I'm there.*

Connecting Therapeutically: The How of "Nurturing Connection"

In order to care for spiritual needs, nurses need to attend with full presence to their clients' concerns. To provide more detail about how these nurses provided spiritual care, a number of related concepts and properties need to be explained. Presence was enacted through a process of therapeutically connecting in a variety of different ways, and therapeutic connection occurred through a take-and-give process of assessment and intervention activities. The properties of assessment included caring, respecting, empathizing; being open, nonjudgmental, and client-centered; being sensitive; listening and walking/sitting with; exploring, questioning, provoking thought, and reviewing life; and checking, making time, and following through. The properties of intervening spiritually include touching, seeing, and embracing; advocating, enabling self-control, and attaining permission; encouraging and supporting; referring and reconnecting; providing information, story teaching, and sharing personal knowledge; and centering and using mindfulness therapies. The properties of intervening mystically include praying, giving it to God, being God's conduit, creating an environment for religious practices, and intervening religiously.

Bea described the beginning of the assessment process and the underlying client-centered motive for nurturing connection:

> *One of the things that I thought was extremely important was to get a sense of where this individual was coming from. . . . I did a lot of listening and tried to determine, Where do you see me fitting into this journey that you're taking? . . . Is it just my presence? Is it my peacefulness with who I am . . . that might . . . contribute to their comfort? . . . I would be open for any question that was asked.*

Basic to the process of connecting therapeutically was caring, being genuinely respectful, and being empathetic.

Assessing Spiritual Needs

Caring, respecting, and empathizing. To care for the spiritual needs of her geriatric clients, Elaine suggested simply treating them *"like the human beings that they are, . . . just to grant them dignity, . . . just trying to be empathetic and being able to call them Mr. or Mrs., . . . giving them that due respect that I would want for myself."* Drawing on the Golden Rule of beneficent reciprocity, Helen also found that her patients opened up to her when she attended to simple comforts:

> *I have always been one to treat others how you want to be treated. You get a lot further from that. . . . Even your most difficult patient—the drunkest, the most combative—if you give them a little bit of respect, some kindness, some compassion, then you avoid all that difficultness, . . . and then they open up to you. . . . Then you can kind of see more where they're coming from.*

Helen emphasized the importance of offering simple comforts:

> *When the patient passes away, often I am the one to go to the family and provide support, . . . simple things, like getting a nice glass of water or Kleenex or chairs to sit around the body, . . . because, well, spirituality is [pause], it's being comforting. It's not rambling on about Jesus and God. . . . I think through your actions you show a lot of care and compassion.*

Being open, nonjudgmental, and client-centered. Discussing the need for being client-centered and open to exploring concerns that were traditionally socially taboo, Bea said that it is *"very important for me to recognize that there is a spiritual component to every human being, . . . I wanted them to know that it didn't frighten me, that I was open to whatever."* She explained:

> *I think that spirituality, when it relates to the God part, can be considered, a very private thing. People say, "Politics, religion, very private; don't go there." . . . In recognizing spiritual-emotional distress, I just wanted them to know that from a holistic nursing standpoint, that* I do go there, *if they so desire.*

Being sensitive. Part of being client-centered is to be sensitive to manifestations of different cultural practices, religious beliefs, and levels of ability. Carol said:

> *I think it's really important to know the cultural component. . . . That needs to be brought into spirituality as well. . . . I need to know . . . how to interact with them, . . . how they relate in their community, . . . the hierarchy of their family, what traditions are important to them.*

Using an example of her Inuit clients, Nadine explained how she adjusted her assessment and care practices:

> *When you're talking about death, you never said to them, "How many times"—because you don't talk about death; it is accepted. . . . You would say, "How many times did your belly swell?" and then, "How many children did you name?"*

In an attempt to be sensitive to the unique perspective of her severely disabled patient, Elaine used his CD collection as a tool to interact with regard to spiritual questions. She commented:

> *Just for me not to be able to speak would be horrible. . . . I could just feel his distress. Thinking, What must he be thinking about? Dying or thinking about going on with his life? . . . The decision . . . to be resuscitated?—all those spiritual questions.*

Trying to be perceptive to his needs, she "*thumbed through his CDs and made comments that he could answer yes or no. . . . He would nod his head or shake his head.*" Elaine added, "*I still saw him as an* individual *with some* value *and that he is unique and that he hasn't lost whatever* maintains *him. I consider that essence of a person, sort of spiritual.*"

Admitting that she found it more challenging to address the spiritual needs of patients whose religious beliefs were different from hers, Fran stressed the need to remain open and loving. She believed that spiritual care for those who do not have religious needs includes being supportive, offering time and resources, asking about culture and faith, and asking about coping mechanisms.

Listening, walking/sitting with. A fundamental and recurrent theme was the usefulness of client-centered listening. Metaphorically, the participants repeatedly referred to the need to walk with clients as they journey through struggles associated with a health/illness event. However, in the beginning of their careers many of the participants were unaware of the therapeutic impact of listening. In facilitating an awkward interaction between an emotionally estranged couple, Ann said, "*I honestly didn't think I said much of anything, I just kind of listened to her and, and talked to him a bit.*" Bea explained, "*They're on a journey, and you come along for a ride*" through listening, presence, and companioning. Speaking from the perspective of a patient, Gail spoke of nurses who were not of her faith tradition being surprisingly facilitative during the resolution of her spiritual distress "*It was other people—in this case, nurses who were not . . . born-again Christians, so the right kind. They were the ones who were there beside me.*" From a nurse's perspective, Mavis described the way in which she had nurtured connection with a patient; she had experienced circumstances similar to Gail's:

> *I would go and sit with her for like a half an hour, and we'd never say a word. She didn't want to talk to anyone, but I always went and sat with her. And then one night . . . she reached out and took my hand, and we still said nothing. But to me that is connecting. She knew that every night I would be there.*

Ann learned that by "*just pulling up a chair, . . . people immediately start talking.*" Speaking of an incident in which one night she discovered her patient crying and feeling exceedingly frustrated, Fran summed up the usefulness of listening:

> *I think people need to* know *that we're not just there to* do *the tasks for them. We're there to almost identify with them . . . in their suffering. . . . You* don't *know exactly what they're going through. But to say, "It must be really hard for you. What can I do?" A lot of times people say "Nothing," but there's always something—just sitting there with them. Sometimes you don't have to say anything; you can just sit there and hold their hand.*

Exploring, questioning, provoking thought, and reviewing life. Combining careful client-centered listening with thought-provoking questions, the participants helped their clients to explore the meaning of circumstance in their lives. Dana advised nurses to *"ask questions that lead them to think,"* and Bea assessed clients whose faith she did not know by asking, *"Could you help me to understand more about your faith and how it affects the way you manage your life and life circumstances?"*

Jane felt that her spiritual care depended on her rapport with a family:

> *To sit down with them and explore some of the stuff that they're feeling . . . depends on the relationship. . . . If they've been open with it, I have prayed with them and talked with them and . . . just let them pour out their heart and not really said a whole lot, but just being there for them.*

Working with geriatric residents, Elaine facilitated reminiscences to access and address spiritual needs:

> *The largest role I have . . . is . . . having conversation, . . . sort of a life review. . . . I find . . . people start talking about . . . spiritual things: what gives their life meaning, what . . . they did, what they regret, what they learned. . . . Sometimes it turns into a discussion about faith or about their general optimism or pessimism about life.*

Other participants expressed the need to help patients and families work through coming to grips with decisions that pose ethical dilemmas. Dana gave an example:

> *We have several patients on vents who are discussing being disconnected. . . . It's very much a preplanned death, and we would never have that discussion without discussing religion and spirituality . . . .*
>
> *We have agonies about other religions and trying to find ways to balance that spirituality with . . . this deteriorating body. . . . So for me this was a whole new learning: . . . finding . . . a religious person from that religion, talking to them, helping to teach us about it. . . . If his values won't let him [disconnect from life support], then can we help him find a meaning and purpose in staying alive?*

These nurses needed to provide unconditional support even when their clients made choices that they would not make. Jane emphasized the need *"to support that decision whether or not I agree with it."*

Using a personal example, Mavis described how to help patients assess the effect of mystical experiences on their well-being:

> *My mother was killed in a car accident. . . . I went . . . to pack up their house. . . . They had a house with a big window and lived right on the lake. My mom loved sitting and talking. . . . And I turned and looked, and there was my mom sitting on the chair looking out over the lake. She was smiling, . . . and I thought, My God I must be losing it' But it was . . .* very *comforting to see her smiling.*
>
> *When I have been with patients saying things like that, I ask them if it is comforting. And if it is comforting and it is good, then to help them to develop that and make it a part of what they are doing.*

Checking, making time, and following through. Other important activities for assessing spiritual need are checking, making time, and following through on commitments. In her parish nursing practice, Ann spoke about phone-checking *"to see how things were coming along."* After attending a spiritual healing with other church members, she described her continuing role compared to that of the others: *"They never saw the people again. It was just a one-time thing. . . . I was the person that followed through on it."* Making time in a busy practice for spiritual care is a consistent theme in the data. Like Ann and other participants, Elaine said, *"Sometimes I stayed late, . . . or sometimes, just in the time that it took to prepare somebody's pills and give it to them, we'd have an exchange."* Fran commented, *"I think just letting people know that you really care about them . . . helps to make a difference, and spending that extra time and effort with them and going out of your way."*

Intervening Spiritually

Other aspects of the process of connecting therapeutically involve various client-centered aspects of intervening. Strategies draw on specific nursing modalities that are often not directly associated with religious beliefs and practices. Some include using a caring touch, enabling client control, encouraging, providing information, and sharing personal knowledge. Some participants also used various mindful energy-based therapies such as therapeutic touch.

Touching, seeing, and embracing. Carol commented on the spiritual part of nurturing connection that happened during routine physical care: *"You can have a spiritual experience with a patient when you're doing nursing care. . . . [For example, during] foot care, you are massaging cream into the feet, and you might be talking about how they feel about life."* Mavis suggested assessing openness to physical connection through spiritual means: *"I think with an aura you know whether or not you can touch someone . . . emotionally or physically."* Citing her own experience of being a patient, she endorsed the profound healing effect of receiving physical care:

> *I think of a time when I had a hysterectomy. After, this nurse was bathing me, and it was the most warming, spiritual, caring, feeling I have ever had. It was wonderful! Just that caring touch of, it was absolutely amazing. I will never forget it—and I don't know who she was, which is sad.*

Advocating, enabling self-control, and attaining permission. Another part of intervening in a client-centered way is to help patients understand the need to take control of decisions regarding their health and health care. Carol said:

> *I see my role also as to advocate for them or to empow—empower is the wrong word. I don't have the power to give to them, but I need to help them understand that they need to take that power. . . . If we are operating as spiritual beings, we need to know that we have the power in our own lives to make whatever decisions.*

Part of advocating for client control is the need to gain permission for spiritually based interventions. Nadine explained:

> *In my belief system it says, "Do what you will, but harm none." . . . You have to have permission of the person before you do anything. . . . When . . . they're willing to accept this ball of positive . . . healing energy—blues, and greens, and golds—. . . let their higher self take it. . . . My belief is that, unless a person has given me permission to do anything, then I have no right to interfere.*

Encouraging and supporting. To illustrate its usefulness, Ann told a humorous story about her clergyman husband, who found that encouragement worked much better for combating her depression than reciting Scripture did. She explained, *"When I got home, he did try some of what he'd learned. He . . . read Scripture. . . . He eventually got* *so frustrated, he threw his Bible across the bed!"* She chuckled and continued, *"It didn't help a bit, so he gave up trying that route. . . . I think his way of dealing with it was encouraging me."*

Reconnecting and referring. Although most participants noted that they made referrals to others for certain kinds of spiritual care, they usually cared for spiritual needs through basic nurturing interventions. Bea said, *"I wanted them to know . . . that I was open to whatever, whether it was reading, just listening to that spiritual distress, or referring them to someone that was better prepared than myself to work with them in that area."* Spiritual well-being is also fostered by facilitating reconnection with estranged family members or with faith traditions. For example, Ann related, *"This lady had Lou Gehrig's disease. She didn't know her diagnosis . . . . She had a daughter living in town that she hadn't talked to in two years."* Describing how frustrated the woman was, especially with her doctors, Ann suggested to her:

> *Maybe it's time to consult the Great Physician. . . . It says in Scripture that if you know you are troubled, . . . you should call the elders of the church and have them lay their hands on you and pray over you. Would you like to have that kind of experience, because I could arrange it?*

After the healing session was completed, the woman cried gently and said, *"All that just brought back everything that my mother had taught me, and what I learned in Sunday School and I've left behind."* Reflecting on the incident Ann reported:

> *The men that were with me didn't see any results of that healing circle, but I did; I saw lots of it. . . . She never got physically better. . . . She did have healing. It was in her . . . daughter that she hadn't talked to for two years. She got reconciled. . . . I think . . . her prayer was answered. . . . She . . . died in her arms.*

Ann's intervention reconnected the woman with her daughter, her husband, and God.

The participants also talked about incidents in which they had more difficulty facilitating reconnection. Lois believed:

> *If they've been separated from their church or path, reconnecting may bring them comfort, so offering them . . . chaplaincy consult. . . . It's harder for people who are pagan or Wiccan or out of the mainstream, because often the Chaplaincy Departments don't have the nontraditional clerics on the Chaplaincy Board.*

Providing information, story teaching, and sharing personal knowledge. Many participants described unique client-centered ways of providing information and connecting through sharing personal experiences. Ann spoke of depression: *"I guess there's people . . . who it has helped, because I've* been there. . . . *It was hard at the time, but it was a good experience. . . . I know now, in my parish nursing, what they are going through."* Nadine added, *"We can perhaps provide people with information or with experiences of our own that may trigger some things in them."* In addition to Nadine's earlier story about using story to intervene with Inuit elders, Mavis explained that, after listening carefully, she built on her patient's story, and she told another symbolic story. This teaching-through-story intervention helped to reframe the patient's outlook and initiate health improvement:

> *There was a lady . . . [with] a very odd disorder. . . . Even . . . the air moving against her leg was painful. . . . I spent a lot of time talking to her. She was very depressed. You could just see that she had darkness about her. . . . You could feel it. . . . One day she said, "I'm a bad apple. . . . It's like I am rotten. Everything I ever touched goes bad. . . . My being sick . . . pushed my sister away from me."*
>
> *I thought, Okay, she has given me this story so I can give a story back . . . about an apple. I said, "If you have an apple and it has a bad spot in it, you cut it away, right?" . . . She said, "Yes, and then there is nothing left." I said, "But there is. Look what's in the middle of the apple. There are seeds. You can plant those seeds and grow them and start over again." That darkness lifted from her. It just* lifted. *You could see it leaving. She started to get much better. Now, I won't take the credit for that; I think it is something that happened within her. But it changed her aura; it changed her whole attitude. She started doing things, getting up, going places, and taking part in things. When she left hospital, . . . she came back and she brought me a card. . . . On the inside it said, "My seeds are growing."*

Centering, laying on of hands, and using mindfulness therapies. In addition to Ann's description of a spiritual healing ceremony, many participants described using various other techniques to center, ground, and focus their mindful intent of moving healing spiritual energy. For instance, referring to Reiki and therapeutic touch, Carol said:

> *We're just on the tip of the iceberg about how things work. We've got this scientific part down pretty well, but we don't know what else is out there energywise. . . . Sometimes they're very healing, and, ya know, they connect with people's spirituality. [She added,] Whether it opens up things for them so that*

> *they can relax enough to talk about things, or whether it just calms their spirit, . . . I have watched people visibly relax with that kind of modality. . . . But this is a very fine scientifically-based hospital. That means [pausing and cautiously continuing,] we don't necessarily recognize that kind of thing.*

Lois said, *"When I practice Reiki you can sense a change in the energy fields, and it's very much an energy shift . . . .I put my hand in the aura, and you can feel the change in the energy."* Some participants knew little about these practices. Some used these techniques in the context of religious practice, and others approached alternative therapies from a neutral or secular perspective. Intervening through working with energy paralleled the religious practice of praying. As well, the practitioners described acting as a vehicle to funnel healing energy through an individual at different physical, emotional, and spiritual levels.

Intervening Mystically

Praying, giving it to God, and being God's conduit. Connecting therapeutically pertains not only to the relationship between a patient and a nurse, but also to the connection between them and the Mystical Beyond. There is also a notion of connection between different events experienced in life in order to gain an understanding of some ultimate purpose. Carol recalled dealing with an unexplainable tragedy: *"I have to believe there is a greater meaning. . . . I don't think I could do this work if I didn't believe that there was something else in charge that had a master plan. . . . [It's about] our soul's evolution."* Describing her connection to mystical knowledge, as many other participants had similarly observed, Carol explained, *"Sometimes I've waited for God to hit me across the head. . . . When I sense that kind of little voice, that little thing that says, 'You should do this,' I pay attention to that now."* Daily, Carol made time to reflect and pray and tap into Divine energy. She added:

> *Meditation is really important for me. . . . I think it gives me the energy to do what I do. If I connect with my Higher Power . . . I get the energy from there, and it comes through me. . . . I'm more of a conduit. . . . When I do my morning meditation, I say, "God, thank You for letting me be Your hands in the world."*

Like Carol, Fran and Ann spoke specifically of calling on God to help them to intervene effectively. Fran said, *"I like to pray and say, 'God, I pray that they can see Jesus* *through me. . . . With Jesus I have enough love for everybody and I can help to carry them through this terrible time.'"* Drawing on prayer and Scripture for guidance, Ann found that her attitude towards her patient completely changed. She explained:

> *So I just prayed . . . that somehow in that little old lady I would see . . . "a drink of cold water to someone in My name is like doing it for Me." . . . Basically I just said, "I can't do this; I can't love this lady. You're going to have to love her through me." . . . I saw that lady completely different; I saw her as God in her, as the person I was serving, which was ultimately God personified.*

For Fran, night rounds provided an opportunity to spend extra time with fearful patients:

> *You'd do rounds every hour, check on your patients, and some of them would be awake. . . . And so I would sit on their bed, give them a back massage, and pray for them. And it felt like such a* God-given ministry.

Creating environment for religious practices, using Scripture. Part of addressing spiritual needs included assessing, making arrangements for, and helping with religious practices. Carol explained: *"I just go into it and say, 'Do you have any spiritual practices that make you comfortable and help you to feel safe? . . . Can I help you with that?"* She clarified, *"I wouldn't say I'm pastoral care per se. . . . If people said, . . . 'I would like to see a pastor; I'm really frightened,' then I would probably hang around and do some spiritual talking about their faith and their belief."* Carol noted more recent efforts to include non-Christian spiritual needs in hospital services: *"We've made a Muslim spot in the chapel for people to go and do their prayers. . . . Probably eighty percent of the time I make people aware that the chapel is there."*

Several participants, who drew heavily on Christian doctrine for guidance in their personal lives, used religious Scripture to intervene. Although all emphasized the importance of guarding against expressing their unsolicited religious beliefs and following the patient's lead, one held a more fixed belief about the validity of her particular faith tradition: *"I believe that the best place to refer people is directly to God's word, . . . and God's word to me is the plumb line. If it doesn't match with God's word, then it is a diversion."* This participant did not have much room in her belief system for religious ideas and practices outside of her own. On the other hand, Bea described how she used Scripture, making sure to follow the patient's lead:

> *They've indicated in the first place their interest in being taken to the Source, because they're searching for questions that can't be answered on a human plane. So I walk with them. I'm very careful that I don't impose, but I* listen *very carefully.*

Intervening religiously. The next aspect of interventions for spiritual care involved participating in religious practices. Some, such as Kate and Mavis, sat with patients of a faith tradition other than their own during religious interventions or practices. Kate said:

> *I've had patients that I'll pray with. . . . I'll say, "I'm not Christian, but I can certainly sit here with you while you pray. And if that works for you, it works for me." I can be open to what they want.*

Mavis spoke of volunteering to be one of the health care professionals present during a religious exorcism conducted in a hospital setting. However, some participants discussed incidents in which some nurses refused to assist clients with practices that did not conform to the nurses' personal belief system. For instance, Nadine said:

> *My roommate was very strong fundamentalist, and she believed only in adult baptism. . . . I said to her, "What would happen if I had a baby? Would you not baptize that baby?" She said, "No I couldn't do that." . . . And I said, "Well, as hard as it would be for me, if you had a baby, because of your belief system I would not baptize your baby, because that would be important for you not to have it done.*

Likewise, even when it was not part of their belief system, Jane reported that nurses performed religious rituals when they were urgently needed:

> *My personal convictions aren't such that you baptize infants. But we provide that "service" to the families all the time. . . . We do our best to get a priest in or whoever. But sometimes the baby's dying and the parents want the baby baptized, and so someone's got to do it. So if that's a need for them, yes.*

Two participants working in the context of a parish nursing practice described taking part in religious healing services. Bea emphasized a holistic approach:

> *I make it very well known when I participate in the healing services that the thrust is body, mind, and spirit. And so when I make my visits, I invariably will ask before I leave, "Do you mind if I have a word of prayer?"*

She noted that clients express different levels of receptivity: *"Some will say, 'Well, that's what I would expect!' or 'Would you?' or 'Oh! Oh! All right.' There are sort of different gradations of openness or expectation."* Ann described the details of the spiritual healing ceremony that she had arranged for her client with Lou Gehrig's disease:

> *There were about four or five of us up there. I went into her room and introduced these gentlemen. Then our Pastor took over. . . . He anointed her with oil. Then we all laid our hands on her in some place. The men were down at her feet and I was up. . . . [She] laid there just wide eyed and took this all in and didn't say a word. . . . When we were finished . . . she burst into tears, and they prayed. Finally, I just said, "I'll just stay with her for a while.*

As Ann described earlier, the result of this service was reconnection with her childhood beliefs, her family, and God.

Although at the time Ann did not immediately realize the full effect of the religious service, she later learned that healing extends from the patient to the family and to God. Others identified religious interventions that include the needs of families and patients. For example, Fran explained:

> *I had a patient; . . . he was to die . . . very soon. . . . His family had surrounded him around the bedside. . . . They came out . . . and they said, "We want to know how we can lead him to Christ so we know for sure that he's going to heaven." And I said, "Well, I could lead him, if you like. I'm a believer, and I know how to lead him to Christ." . . . And so I whispered in his ear basically the steps. . . . As soon as I had finished, he actually sat up in bed, opened his eyes, which he hadn't done for days, and said* "Jesus." . . . *The family were just* ecstatic, *and I just had goose bumps all over my arms thinking he had heard what I said, and he had accepted. . . . He had died while I was off work. One of the nurses said it was the* strangest *experience. . . . When he was taking his last breaths, the family were rejoicing. . . . I see a lot of family, they grieve and they mourn, and it's almost like they have no hope; they don't know for sure. . . . [This family] had that confidence in knowing they would see him again. Before, they didn't know for sure.*

In this section I have shown how the participants nurtured connection. They made therapeutic connection through a take-and-give process of assessment and intervention. The properties embedded in this intertwined caring process include traditional client-centered nursing practices and some less traditional spiritual and religious interventions.

Who Connects Therapeutically

Spiritual Care Specialists

Now that it has been established what spiritual care is and how nurses care for the spiritual needs of their clients, one might ask who else practices spiritual care and in what way it differs from nursing practice. Ann attributed some of her learning to attending a chaplaincy course. To determine how she would care for spiritual needs, she questioned, *"Maybe there is something different about those chaplains. . . . They're really there. It's the difference. They are present and listening."* Nadine described the physical, psychological, and spiritual healing roles and limitations of Shamans. For example, she said, *"Aboriginal peoples believe . . . if you are given the bone, . . . you will die. You are cursed, and only another very strong medicine man can pull out the bone. . . . They go into dreamtime; they wrestle with the spirit."* When I asked whether nurses were Shamans, Nadine responded, *"Absolutely not. . . . This is a trained person, . . . a specialist. It's not a nurse. But what could happen is the nurse can assist the specialist."* She likened this to a time when she had *"assisted the rabbi to do a circumcision. I was Catholic and he was Jewish, but they needed to have a nurse to assist in that particular role, . . . to set up an atmosphere."* In these and other data I needed to determine whether the notion of spiritual care, the ways of intervening, and the ways of leaning were significantly different between nurses and other spiritual care specialists. Therefore I selected Paula, a pastoral care professional, and asked her the same questions that I had asked the nurse participants.

Paula described the notion of spirituality, interventions to care for spiritual needs, and ways of acquiring knowing in an almost identical fashion as the nurse-participants had done. For instance, Paula explained that, although some might assume that chaplains would be ministering a particular religious agenda:

> *Each of us come rooted in our faith tradition, but open to every person who comes to us and what their faith or no-faith background is. . . . We embrace people of all faiths and sometimes help them to work through whatever it is in their faith that they're struggling with.*

She said, *"Ministry in a context such as an acute-care setting here is being present to people and being there."* Paula explained that clients do not often name their spirituality as *"'This is my faith, this is my religion,' but the way they live in relationship to God and to others and to the earth.* She said, *"Relationship is very important. . . . [It is] their connectedness."* When I asked her how she intervened with a particular case, Paula replied, *"Well, what I did was to really listen to her story and to support her in . . . a really, really tough, tough situation. We journeyed together for a significant period of time."* She continued, *"I really have to shut up and listen, because I don't have an answer . . . for why things happen, and I don't think anybody does. But you can be there."* Paula said that some of her knowledge for spiritual care came from continuing education and some medical, psychological, and theological theory; but most came through personal experience and being open to self-reflection. She felt that some of her supportive ability came naturally but that she learned primarily through developing her own faith, ways of praying, and reflective practice. She also drew on Divine sources of knowledge by asking God to help, being still enough to hear the answer, and accepting the answer she received. Sometimes she would explore issues with like-minded, encouraging people and with those who held a different perspective. Although Paula explained that nurses, social workers, and pastoral care professionals share clients and intervene in similar ways, she also distinguished an area where spiritual care occurs that is uniquely in the domain of nursing. She said that different disciplines have different parameters to deal with problems and that *"nurses are so intimate with the patient. They are there on many, many levels, . . . [especially at the] bedside, to do intimate personal care."* For example, she remembered, *"This patient was an elderly male just naked, and as I passed by, I saw that through the curtain. The nurse was dealing with such respect for him and explaining everything. . . . He couldn't do anything for himself."* Paula identified the unique opportunity for spiritual care: *"So that personal, physical intimacy is a place where a level of trust is built. . . . At those times bits of conversation happen between a patient and the nurse about the illness, . . . the hospitalization, the diagnosis. That doesn't happen at any other time."* She linked this kind of spiritual care directly to nurturing connection:

> *I'll go back to talking about relationship. Spirituality is relationship. At that point of intimate care, the nurse is giving physically to this person; it is probably as close as making love. . . . But the presence—there's something quite profound about taking care of somebody who is so vulnerable.*

Carol concurred with Paula:

> *I don't know any job that allows us to be with people like nursing does. . . . We're with people—on all kinds of levels. We get to connect. Physicians don't. I don't think other areas of practice get to see people at their most vulnerable times.*

Unique Domain of Nurses

Several participants noted special opportunities to address spiritual needs. Gail discussed the sense of vulnerability that she had witnessed in her patients:

> *They may not want to do that with their family and friends . . . .It's a very special relationship with the nurse. It's an opportunity that's different. . . . See, I think sometimes nurses provide a lot of spiritual care when the person's on the toilet or in the bathtub. And pastoral care isn't going to get in those places.*

Referring to her own experience as a patient, she explained:

> *The first time, I thought I would die at the thought of . . . having people wash me. . . . You are so grateful for the person that does that efficiently and well, but even more grateful for the person that does it with care and gives you that little bit of dignity. . . . This may be something so difficult that they will never voice.*

Lois added, "*Nurses in particular have such a unique position in the inner personal space of our patients. We're uniquely positioned to be able to ask what are their spiritual needs.*" She spoke of "*the image of nurses being care providers, the nurturers, and very much tied in with the role of women. So we're often allowed into patients' space where other health-care providers aren't.*" Speaking from a personal perspective, Lois explained:

> *For me, I'm more likely to talk to a nondenominational nurse about spiritual distress than I will ever be talking to a Catholic priest, . . . because I would make the assumption that . . . the culture of that denomination would place binders on that particular cleric's ability to think outside the box.*

Part of the unique position afforded nurses to address spiritual needs pertains more specifically to where and when the connection occurs.

Where and When Spiritual Connection Occurs

In considering how nurses address spiritual needs, the next question was, Does the practice of nurturing connection happen in all sectors of nursing? Are there specific times, places, or areas of practice for connecting therapeutically? In the first interviews the participants expressed the opinion that they doubted that spiritual needs were addressed in all practice settings. Several related how the trajectories of their careers led them to positions in which they were more able to nurture connection.

Bea, Carol, and Dana recalled the pervasive influence of the presence of religious sister in their hospital-based education programs. However, they had mixed opinions about the long-term effect of this kind of role modeling and the level of support for spiritual care in secular urban and rural hospital. Having recently accepted a position in a faith-based institution, one nurse said, *"Depending on where you work, . . . it is . . . permissible."* Comparing her experience in another secular urban hospital, she said, *"There wasn't the same amount of spiritual care on staff."* As for support for her practice of spiritual care in the faith-based organization, she said, *"A chaplain . . . is considered part of the interdisciplinary team . . . So just having that presence opens it up and invites it . . . without anybody raising any eyebrows."* However, other participants gave examples of feeling supported with their spiritual care interventions in non-faith-based work settings. Perceptions of the influence of working in a faith-based environment were not consistent among participants.

Amongst the ranks of nurses, there were mixed opinions about in which specialty areas spiritual care interventions would more or less likely occur. Lois suggested that spiritual care depends on the patient population: *"I don't think that emergency nurses are going to recognize people's needs to connect."* Carol said: *"There is that hierarchy. . . . I remember when I got into nursing, . . . I went right into medicine, and my classmates were going into ICU. [They said,] 'Oh, you're doing geriatrics?' It was undervalued."* Surprisingly, when Carol transferred to a mental health position, she found, *"I love this! I would do this for free! . . . I can spend the time talking to people."* She added that, in comparison:

> *We do consults in ICU, and I say to the nurses, "I'm glad you're able to do this, because it's not something I could do. I need to be able to talk to people. That's what I love to do."*

Considering these and other data, I determined that I needed to recruit participants from more highly acute areas of practice such as intensive care settings. Although all cited lack of adequate time as a significant factor, Fran, Helen, Jane, Lois, and Nadine discussed numerous ways of addressing spiritual needs in emergent or highly acute practice settings. Helen said:

> *Sometimes there isn't much time, . . . especially in emergency. You might be sitting with a family, and then a code comes in and you've got to leave them. But I always try to come back, . . . because to them their situation is an emergency too.*

All of the participants demonstrated that their practice of spiritual care had grown over their careers. Several described choosing positions that they felt would give them more time to interact with patients. Ann explained that, after a long career in diverse areas of practice and teaching, *"I think the reason I like working on the Alzheimer unit is there I find that I can be that presence . . . to fill their needs."* Referring to another area of practice, she continued, *"Most of my examples when I have been able to provide spiritual care are actually in the last few years doing my parish nursing, because there, they ask for it. So it is so easy."*

The next consideration was whether there was an optimal time of day for nurturing connection. Overwhelmingly, the participants described moments of spiritual care occurring at nighttime. Fran recalled:

> *When I first graduated from nursing I was working in general surgery. . . . [It was very] technical: Do this and do this and do this. . . . I felt frustrated because I had no time to sit with my patient, . . . and I wanted to really get to know who they were and how they felt. . . . It wasn't until I worked nightshift that I had the time.*

Lois had worked in an intensive care setting and spoke of *"the tears in the middle of the night"* as she intervened with her client's family. She explained:

> *It's the family that needs the spiritual care. . . . There is a parent . . . holding the child's hand, . . . and the tears are just coming down. Sometimes the only thing that you need to do is just stand next to them. . . . The acknowledgement, the touch, . . . the affirmation that, 'Yes, I recognize you're in pain.' There is the*

> *touch that builds a physical connection, an emotional connection. . . . They'll just cry on your shoulder, and you just hold them. . . . And then they get through that phase. You get them a Kleenex . . . and give them a chance to just talk about how helpless they feel. So the connection there is the empathic listening. . . . You make sure that that person is . . . connected with somebody.*

Speaking from the perspective of both a nurse and a client, Gail added, *"It's a sacred moment, something to be really taken seriously. . . . It may only be that one moment, and that person may never allow themselves to be quite that vulnerable ever again.*

Although it was not an intended focus of the study, the perspective of the recipient of therapeutic connection was also needed. As will be seen in the next section on Needing Connection, some participants were able to speak from a patient perspective. To better capture this perspective of where and when spiritual care occurs and its effect, I used the strategy of selectively sampling the literature. I referred to findings published in a previous study of spirituality in nursing (Hood Morris, 1995). One woman's comment epitomized the timeless connection created through a simple moment of nursing care:

> I was feeling very anxious. . . . A nurse who was just checking on me realized that I was awake. . . . The bottom line is, however, I responded to her, made her sit down in the chair next to my bed and hold my hand and say, "Do you want to talk about it?" I have absolutely no clear recollection of anything that was said between us, except that . . . I felt enveloped by this feeling, caring and nurturing and warmth.
>
> What is really remarkable to me was that months later when I was readmitted for another reason and was in tremendous pain, I remember being transferred from the emergency unit to the floor and hearing a voice saying, "Oh, . . . here you are again" and recognizing that voice, not seeing her. I didn't have glasses and I wouldn't be able to recognize her, but hearing that voice and that same feeling of warmth and protectiveness and security. I felt that same feeling again and it was the first moment. (Hood Morris, 1995, p. 80)

Needing Connection

No exploration of how nurses learn to care for spiritual needs would be complete without presenting the perspective of the recipient of care. Although this study focused on the perspective of nurses, the participants were also able to provide examples of incidents and thoughts on connective needs from the client perspective. Several gave detailed descriptions of spiritual needs that arose from personal experiences as recipients of spiritual care. As well, to add scope to this study, I also selectively sampled from the literature a few incidents of needing connection from the perspective of actual clients. Moreover, learning about connection occurs as a direct result of engaging in a nurturing relationship from the context of being a client. Therefore, the needing connection theoretical category captures the client part of the basic social process of "connecting spiritually." It represents a pattern of cause, action, and consequence.

First, I identify some indicators of the spiritual need along with some barriers. These represent the signs and symptoms of spiritual distress. Then I present certain requirements and actions of clients to connect with a helper. Here, in the process of engaging in spiritual care, clients risk disclosing their vulnerability. They give their concerns to a nurse in order for the nurse to help them to explore deeper meaning. At times nurses also manifest spiritual needs and may assume a position of needing connection. Therefore, sometimes nurses nurture other nurses who need connection. From the perspective of a nurse, the needs and patterns of giving and receiving spiritual care often shift back and forth in a progressive process of learning about spiritual connection. Finally, I present some of the consequences experienced by clients who connect with the nurturing activities offered by nurses. These outcomes result from their needing connection and taking action to engage with spiritual care.

Indicators of Spiritual Need: The Causes

Often health/illness circumstances put clients in a very vulnerable position when they risk disclosing sensitive personal fears and information to nurses. Faced with thoughts and questions of a spiritual nature, patients are not only confused about their own health/illness circumstances, but are also uncertain about the receptivity of the care provider. Gail explained, *"When you are a patient, no matter how much you know, . . . you are really vulnerable."* Referring to a need to be *"taken seriously . . . because . . . that person may never allow themselves to be quite that vulnerable again,"* she continued, *"If you have somebody that can still look at you as the person, . . . the one person who says, 'How do you feel about losing this baby?' instead of saying, 'You passed tissue,' that brings back . . . the hope."* Therefore, hesitancy to share spiritual concerns with a nurse indicates an underlying doubt about the receptivity of the nurse and the acceptability of the source of a client's distress.

Not only do patients have a need for nurses to be sensitive, but they also have a spiritual need indicated by spiritual distress that results from interactions with other people. Speaking from the client perspective, the participants gave examples of the negative effect of insensitive pseudo-spiritual actions performed in the guise of religion. These incidents were usually perpetrated by well-meaning friends, family, or religious representatives. Clients who appear unusually disturbed following a visit may need protection from so-called spiritual assistance. For example, during recovery from a surgical intervention, Dana described being visited by a couple with a particular *"religious conviction."* Feeling vulnerable and trapped, she said, *"That was irritating to me that day. I was feeling that they weren't feeling very attuned to people's needs."* Dana added that in her future nursing practice she watched for and shielded her clients from those kinds of unwanted visitors.

Like Dana, during her illness Gail encountered a disturbing visit from fundamentalist Christians who undermined the medical treatment that she was receiving. She related:

> *I had been faithful and active in my church. . . . But there were some people who really laid those kind of guilt trips on. [For example,] you shouldn't be in the hospital taking medication because prayer and faith was the way to go. You weren't relying on God enough; therefore you couldn't get well.*

She said, *"This was the propaganda that was preached to me. At one point I actually had a minister who said to me that he felt I was possessed by the devil because I was depressed. . . . I was* horrified *and mortified."* Gail explained to the nurses that she needed to be protected from this religious representative, and they offered to restrict her visitors. While sick, she felt too vulnerable to deal with his insensitive opinions because she *"didn't have the strength to fight him."*

The response of patients to the health crisis can range from frustration to horror, but many manifest fear and anger. Lois cited key questions that indicate spiritual distress and lamented that many patients *"can't even control their own anger over whatever is distressing them."* She explained, *"Anger is equated to fear. We can't always express* *fear. So many times it will be expressed as anger."* She said clues that her patients were unable to manage, cope, or find comfort included comments such as that *"God had failed them. Why me, God? God would have never let this have happened to me."* Fear also interferes with connection. In some circumstances there was a reluctance to share personal information and concerns because of the fear of not being understood or being ridiculed. Emphasizing that she needed to earn the trust of her Aboriginals clients, Nadine explained, *"It probably took four months for this young fellow to give me his private . . . spirit name. By then he knew that I would never make fun of it. There was an understanding that he could tell me, and it was safe."* She learned to respect her patients' need for privacy and wait for them to open up to her. She added:

> *You just had to simply respect that there was some areas that you just didn't go. . . . There were times that you would walk in a room, and it would get very quiet, and so you would just simply leave. [Moreover,] they give you sides or faces. . . . They'll show you all of the faces, but it will take a long time. You have to start with respect, and then as they gradually move in, . . . the last thing they will reveal to you is their spirit belief, and that's because that is so private and so internal.*

Therefore, to determine spiritual need the nurses had to be sensitive, nonjudgmental, open, patient, and perceptive to subtle client indicators.

Illness events often trigger spiritual thoughts and questions that otherwise may not have occurred to a person. Describing families faced with a big surgery or the death of their child, Jane noted that this kind of health crisis *"tends to make most people think about spiritual things. . . . It all of a sudden jars them."* She noted, *"All the questions come out: Is there a God? How could a loving God do this?"* To be sensitive to their need, Jane suggested being supportive and saying to them, *"It's okay to be angry."* Similarly, in an older population, Elaine noted, *"When dying, . . .* suddenly *people were more open to spirituality and providing comfort and those types of things."* Their questions focused on the future (especially in the context of threatened death), one's ultimate purpose, and how to prepare for the ultimate end. Bea reported:

> *I remember one individual in Montreal who was terminal but was so very much concerned about "What happens when I close my eyes? Where am I? . . . Am I okay to die? What is dying? What is death? How do I understand it? And what can I do to prepare?"*

Fran felt that spiritual needs include more than just a relationship between the person and God. They extend to deep expressions of feelings and thoughts about one's origin, purpose, path, and action such as, *"How did we come about? Where are we going? What's the purpose of my life? What am I supposed to do with my life?"* Questions of a 'why' nature indicate a spiritual need.

Struggling through faith-based guilt and confusion, Nadine found that some religiously neutral nurses were better able to assist her with her spiritual questions than were her Christian peers: *"Going through my own spiritual crisis, all of a sudden I didn't have all the answers."* Nadine changed because she *"had to really struggle and decide, 'Was this for real? Did I really believe this?'"* In the process Nadine *"went through a lot of soul searching and a time of a real sense of abandonment with God."* However, to her surprise, during this troubled time Nadine discovered that she received the most help from nurses who *"were not identifying themselves as a Christian."* She added that those nurses *"were certainly displaying what I knew as real Christian qualities: acceptance, kindness, patience, understanding, empathy, support [laughs], not judging you"*; whereas she felt that her Christian friends gave her *"another dose of guilt for not having enough faith."* She complained, *"You were supposed to be this incredibly loving, caring person."* If you were not, *"then you weren't living quite right.* She understood from her Christian peers that *"if you were sick, you were still supposed to be really on top of things."* It was unacceptable to be discouraged or depressed or to wonder where God was in her troubles. If she told her peers that she did not have enough faith, they would give her *"the platitudes: 'You just have to put it in God's hands. You just have to pray more."* Nadine lamented, *"It didn't work for me. It wasn't helpful, and I didn't feel supported at all. I struggled a lot. I felt a lot of guilt and a lot of confusion."* Nadine's story shows how the process associated with needing connection is inextricably connected to nurturing connection. As well, personal learning is connected to professional learning. Through taking the nurse's connection, Nadine joined her patient perspective with her professional perspective in the interwoven processes of addressing her spiritual needs and learning connection.

Questions and other indicators of spiritual need are not exclusive to patients. Sometimes, even in their professional role, these nurses faced issues in which they needed to actively connect with others and the Mystical Beyond. Lois described a crisis situation in which a group of professionals engaged connection in order to proceed: *"I was the first respondent with the police chief and the fire department doing CPR[2] in the back of the ambulance, trying to keep this kid alive."* She noted the spiritual distress of the professionals:

> *I looked at the other guy and we started saying the "Our Father." And the whole feel in the back of that truck changed. Everybody kind of took a deep breath to calm down and to refocus. . . . All we did was say the words. I'm not a cleric; it shouldn't have made any difference to them. But it did.*

Some participants described experiencing a profound sadness or hopelessness in the plight of some of their patients. A few had difficulty emotionally separating from their concern with client problems when they were off duty. Some said that they felt drained. Feeling overwhelmed, depleted, preoccupied, or disconnected re indicators of spiritual need in nurses. Kate emphasized the need to regularly connect with universal energy; otherwise:

> *If I've blocked my spirituality and I'm living in my fear, my doubt, my head, or even just in my body, I'm exhausted by the end of the day. . . . And if I'm busy working on my fear and my insecurities, . . . then I'm sapping my energy as opposed to giving myself energy.*

Kate explained that nurses need to take connection through grounding techniques in order to replenish resources for nurturing connection. She concluded, *"If I can give me energy and I'm full, I've got stuff left over for you."*

The participants reported that some nurses were not as open to perceiving different manifestations of spiritual energy. As well, the fixed religious beliefs of some nurses can create barriers to addressing clients' spiritual needs. For example, Ina stated that the residents rarely spoke about encounters with deceased relatives with their caregivers and suggested that it was because her staff were mostly *"from a Catholic background. They are afraid to talk about . . . paranormal kind of stuff."* She speculated that the staff *"think, 'Oh, she's just demented, and she's crazy,' and so they're not going to listen to it."* Although indicators of spiritual need were present, the caregivers missed opportunities to attend to spiritual needs because of religious-based fear or ignorance of spiritual phenomena.

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[2] Cardiopulmonary resuscitation.

At one point in one of the interviews, a participant admitted believing that

> *a lot of people . . . don't know who rules them. . . . Someone living a godly life wants to be more like Christ, and someone who doesn't live a godly life doesn't really even know the difference between good and evil. I believe that the devil is out to deceive people, and often he will do that by presenting something that seems close to the truth, whether that be another religion and leading people down that path where people are deceived into believing that that's the right way. And in the Bible it says that the only way to God is through Jesus; and so if people take a different path to God, they're not going to obtain eternal life; and that's what's taught in God's word.*

Although this participant gave numerous other examples of learning, nurturing, and needing connection, these kinds of firm convictions left little room for perceiving certain kinds of spiritual needs. Clients who need to take connection by exploring their religious fears would have difficulty in meeting their needs with someone who held such religiously prescriptive beliefs.

In order to understand how nurses learned about spiritual distress and other indicators of spiritual need, the participants were asked whether they had had experience in working with supernatural forces. Some gave examples of witnessing healing attributed to the unknown spiritual forces, but most were unable to specify incidents when they were cognizant of adverse spiritual circumstances. Typical of many, Gail stated, *"As far as feeling or sensing that evil was taking over in somebody, . . . I have to say I haven't really encountered that."* One thought that it would be difficult to discern those kinds of indicators of spiritual need if a nurse's belief system had not evolved enough to perceive supernatural phenomena. Nadine suggested that the spiritual aspect of humans is so connected to the psychological and social that changes in intellectual perception lead to spiritual and even physical consequences. For instance, she noted an incident in which a malicious shaman had put a curse on an Aboriginal patient. Describing how cursed individuals are informed and psychologically doomed to a particular fate, she explained, *"Another individual really wanted this young girl, and so he put a curse on him, and he died. . . . He just [pause] gave up. . . . He knew he was* *cursed. . . . Belief, it has to do with belief."* Therefore from a client perspective, the perceived meaning of an event seems to play a vital role in the health outcomes.

To elicit more specific experiences with supernatural phenomena, I asked the participants for examples of effects of "negative spirituality" on health. Some described the hurtful effect of insensitive behavior. Speaking of the effect of gossip, one participant asserted, *"I believe that our fight is not necessarily against flesh and blood, but against spiritual, different spirits. . . . I feel there is a spiritual realm which involves both evil and good."* Similarly, in association with negative spirituality, other participants cited examples of social sanction within faith groups. However, only one participant, Mavis, reported witnessing what might be deemed by some an example of negative supernatural forces that affected a client's well-being:

> *[We had] a woman who was DID.*[3] *The church was very involved. . . . I struggled with this one. . . . She developed all these personalities. One personality was very evil; . . . it was frightening. I thought it was probably part of her. But the church believed that it was the Devil in her. . . . The physician wouldn't agree to an exorcism unless there were some nurses present. . . . They did all this singing and praying and waving of hands and stuff, . . . and I swear to God, something came out of her mouth . . . [and] disappeared. . . . And after that, that evil personality was gone. . . . I think that is the only time that I ever really sort of believed that there was a God and a Devil. I mean, I wouldn't really believe that except my colleagues were there, and they saw it as well.*

As an indicator of spiritual need, nurses need to assess patients' understanding and perceived meaning of their health/illness circumstances. Indicators of spiritual need are associated with risking vulnerability, expressing anger and fear, asking 'why' questions, and experiencing supernatural forces. By assisting clients in actively engaging with or taking connection, nurses enable them to address spiritual needs.

Spiritual Needs and Actions

Overwhelmingly, the data show that connecting is the foremost spiritual need for patients. Connection most often occurs interpersonally between nurses and patients in the action of talking, sharing, and exploring the meaning behind circumstances. Elaine described her client's need for *"more discussions about meaning or just distress or*

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[3] Dissociative identity disorder.

contentment, or optimism or pessimism, [whether] they felt . . . cheated by God or by life in general, or . . . took things in stride." Nadine also believed that clients need *"somebody to talk to,"* which helps to *"make the pain go away."* Ina emphasized the need for her elderly clients to connect through helping staff, other clients, and maintaining a sense of *"still being useful in life."* Even *nurses* need to talk about their concerns. Gail and Fran talked about the benefit of participating in a support group for staff nurses in their respective institutions. Gail reported that, to address spiritual needs, nurses in her group were encouraged to share and reflect on prompts such as, *"'Tell me your worst experience or your best experience.' And then just, 'How has that affected your practice? Or are you practicing differently because of that experience?"* In this way the nurses learned about spiritual care during the process of having their own spiritual needs addressed.

Connection also occurs within an individual through personal reflection and contemplation and between the patient and the Mystical Beyond. In coping with illness and crisis, Ann noticed *"such a vast difference when an individual has faith."* According to Elaine:

> *People who die the most easily have some spiritual belief, . . . a hope even of something in the next phase of . . . time. . . . I think people who don't have that spirituality have a harder time because it's sort of a blank wall.*

Often these nurses acted as nurturers of connection within and between patients, themselves, others, and the Mystical Beyond. Sometimes their patients needed to connect with deceased loved ones. Ina spoke of a client whose husband had recently died: *"He would come and visit her, and they would have conversations. . . . I don't think she had mentioned that to anybody else."* Lois needed a nurse like Ina who *"would listen, someone who would be nonjudgmental, someone who wasn't afraid to be in the room with one who is crying and upset, someone who provided care, . . . so that I feel connected and I feel tended."* Lois described what it was like having her spiritual needs cared for by another nurse:

> *For that moment, feeling cherished as if I was being held in the palm of the Divine . . . . And when I'm upset, I just want to be held in the hand or the palm of the goddess. Just let the tears come or the pain go away, just to be held, that type of connection with the Divine.*

Therefore, the spiritual needs of clients include a need to be cared for and cared about. When Gail was a patient, she noticed nurses'

> *actions, through their body language, even just the eye contact, that says, 'Are you doing okay?' or 'How is it today?' or 'Is it getting a little bit better?' . . . Sometimes it doesn't always have to be profound reaction. It's the difference between just having a task performed and being cared for.*

Another person, who described herself as nonreligious, summed up the effect of having her spiritual needs addressed by nurses:

> Connection . . . for me [is] . . . the need to share the experience, not from a clinical perspective and not from a physical perspective, but from a spiritual perspective, . . . to have somebody to be able to come into my room and look into my eyes and hold my hand. . . . There doesn't have to be any communication at all. . . . When it has worked, it's like floodgates that have been holding back a dam open, and there is this tremendous release of energy and force from one to the other. . . . It's such a cleansing experience. . . . I remember those individuals in my life with a clarity that everything else in the process has lost. (Hood Morris, 1995, p. 68)

This patient also noted that her spiritual needs had been met more through illness and struggle than through happiness:

> I grow spiritually through, it's not necessarily health, although health is one of the markers, but pain, and whether that pain is associated with loss of people that you love. . . . That is how I grow. I don't grow in happiness. When I am happy I am content to live my life as a human being instead of a spiritual one and while I connect with the spiritual in me, you have to work at it rather than having it impinge itself on you so forcefully that you cannot put it aside. I think that is the essence of it. When you are ill, you cannot put it aside. (Hood Morris, 1995, p. 56)

Thus, it is important for nurses to understand that the spiritual distress that results from illness experiences are important tools for spiritual development and that the best way to facilitate spiritual growth would be through helping patients to explore and find meaning in their circumstances. Just as nurses learn and grow spiritually through struggling through life experiences, so do clients. Therefore the needs associated with spiritual distress have been shown to be a factor in achieving spiritual well-being.

Outcomes of Spiritual Care: The Consequences

Despite the fact that in this research I did not set out to discover the outcomes associated with nurses' attending to spiritual needs, evidence exists in the data of the calming, restorative, and connective effects of spiritual care. When the participants nurtured connection, their patients appeared less troubled and more peaceful and accepting of their circumstances. Ann beseeched God to help her connect with a constantly complaining client. As a result of mainly attentive listening, Ann noticed that the client *"wasn't as troubled"* and that her intervention *"definitely had a calming effect on her."* The participants also cited examples of physical, psychological, social, and spiritual healing. In Ann's example her client reestablished previously estranged relationships with her family, her faith community, and God. Ann believed that, as a result, *"I think she had her prayer answered."*

Although there was some suggestion that nurses may not realize the full impact of their care on patients, several, speaking from a patient perspective, expressed a profound appreciation for nurses who connected with them on a spiritual level. In Hood Morris's (1995) study one said, "There haven't been a lot of instances where nurses have cared for my spiritual needs, and I suspect that those at times that they have no idea. It did not leave them with the same intensity that it has left me" (p. 75). Gail and Mavis expressed similar sentiments and lamented that, although they still felt connected to the healing experienced with a particular nurse, they were unaware of who or where those nurses were today.

When I asked Carol what had happened to her as a result of helping someone with their spiritual needs, she replied, *"It gives me this really warm—sort of,* it energizes me. *It's hard to describe. I'll go home at the end of the day and it's like, 'Woo-hoo!' It's just, I* feel really connected." As described earlier, Carol also discussed the result of acting as a conduit for spiritual healing when a patient was on the verge of dying. She experienced a mystical feeling as she was administering platelets saying she was just *"trying to keep myself open [to] whatever energy was coming through."* Finally, speaking from the perspective of her own spiritual needs, one participant described the need to look for the lesson in difficult circumstances and to accept her place in the outcome: *"I don't need to* *blame outside or external events that happen. I just say, 'Well, God, that's an interesting lesson. I'm not really happy about that.'*" She then revealed:

> *I had a breast biopsy yesterday, and I don't know for five days. That wouldn't be a lesson I'd choose, but, however it's going to turn out, it's going to turn out that way. . . . Whatever's going to evolve out of that is going to take me somewhere I'm supposed to be.*

In summary, this section on needing connection addressed mainly the receiving side of spiritual care, which involves risking vulnerability, exploring spiritual questions, and connecting with self, helpers, others, and the Mystical Beyond. Those who engaged in connection became calmer, accepted new meaning, and felt more unified. The nurses became agents who spiritually transcended and connected time and space in a caring moment. The following client perspective captures the essence of spiritual care indicators, needs, and consequence associated with needing connection. Referring to the Divine, a male Aboriginal man related:

> He sent the nurses. . . . [In] my experience with the appendicitis . . . I was being prepared to learn the true nature of human beings. . . . In one sense I would say that I was 48 years, and on the other hand this was going to the next experience after my mother died. So it was like there was only 2 experiences in my life. And there was no time period between those, just from one experience to the next, 46 years between the two. . . . [My healing was] . . . precipitated by the appreciation that I . . . sensed from the nurses. . . . To me it was like . . . their spiritual energy was focused into the manner in which they did their job. . . . As sensitive and as fearful as I was, . . . it was as if my arms were strapped down and I couldn't protect myself. [But] all these expectations of threats . . . would never happen.
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> One of the more joyful times was when I was getting in touch with my spirit was when at 4 a.m. I heard the nurses taking care of an old woman who was hallucinating. . . . I wasn't watching; . . . I was listening. . . . To me the quality—the tone of a voice carries so much weight. I think it goes back to the respect of the air. People call it gentleness, respectful, but I could almost taste the love. . . . They were trying to take control of the situation and it was early in the morning and they didn't want to wake up other people. But as I lay there listening to them, quietly engaging the person, keeping the person's attention, I knew that they knew what they were doing. . . . .I didn't hear the type of noise that I hear during the day time hours. I just lay there, listening to this interaction; . . . soft, but purposeful. . . . What I was gaining from it was the fact that at any time the quality could be transferred to me. . . . I wasn't thinking but, spiritually, I was reassured and comforted.
>
> Nurses . . . might be focusing on helping to heal physical problems or illnesses, but the manner in which they conduct this activity also addresses the

> spirit. . . . It's just a little bit of that quality which kicks in the healing process within one of their patients . . . in that sense they are agents. (Hood Morris, 1995, pp. 75-76)

Living Interconnection

Along with subquestions evident in the previous sections related to how nurses learn, how they practice, and how clients take connection, another more fundamental question emerged. In the context of connecting spirituality, the final category pertained to the ontological question of how to be spiritual. Although the full development of this question is beyond the scope of this study, properties of living interconnection include distinguishing spirituality from religion; understanding the micro and macro aspects of intra-, inter-, trans-, and extrapersonal connection; considering the purpose and benefit of living and being spiritual; and fitting this within the context of professional caring.

What Distinguishes Spirituality From Religion?

Historically, there has been a great deal of uncertainty over what constitutes religion, what constitutes spiritual need, and how the two concepts interrelate and affect human health and health care. As was shown earlier, most of the participants indicated that when they first began nursing, in their understanding of it, spiritual need was associated almost exclusively with religion. A few drew extensively on religious teachings to provide spiritual care. For the most part, that did not mean that these nurses directly taught religious dogma to their clients. Only one participant believed that she had been called to share her particular religious beliefs with some of her clients. However, Kate cautioned against using religious prescriptions:

> *Sometimes you have religion without spirituality, you can have spirituality without religion, and sometimes you get both. But when you're locked in a dogma, there's a right way and a wrong way; then I think you cut off your spirituality. God is everywhere.*

Some explained that to sustain themselves in their work, they needed more than the spirituality attained through their respective religious teachings and practices. Dana explained that although

> *I have a very structured religion that I find strength, I think it is different. Sometimes . . . my spirit needs to be connected a bit more, not just the religion. In this job it has been even more the need to refresh, to think about my spirituality, to think about connecting well with other people.*

Dana and others expressed a spiritual need to quietly reflect at a deeply personal level on how their spirituality helped them to connect with others. Similarly, Bea observed, *"Some people, when they think of spirituality, they don't think of God necessarily. They think of maybe a connection with people that warms something within them."* Clarifying the difference between religion and spirituality, Mavis referred to a relationship that she had with a distressed client: *"I think this was spiritual. I touched her and she touched me. . . . And I really think it is a spiritual connection."* All of the participants considered spirituality as broader than and slightly different from religion. According to these data, spirituality was confirmed when it was associated with connecting and interconnecting with all.

Intra-, Inter-, Trans-, and Extrapersonal Connection

From the smallest to the largest, the closest to the most distant, and the known to the unknown, the scope of spiritual connection ranged from the miniscule to the All-Mighty. Intra-, inter-, trans-, and extrapersonal properties of living interconnection pertain to relationships within the self, between self and others, among many, and beyond the human self. Building on Dana's previously expressed need to reflect spiritually, Bea believed that, at the intrapersonal level, physical healing is connected to emotional and spiritual need:

> *The broken bone has got to be treated and repaired. . . . The spirit will be connected with that broken bone. . . . There may be a sense of worry, fear. And so the alleviation of that . . . may result from an individual just saying [whispers], "God, please help me."*

As well, Bea connected her personal wholeness with communication between and among others: *"I see my communication, my connection with myself, and with you as another individual and with God as being pivotal . . . to my wholeness."* Similarly, Kate linked intraphysical client need with spiritual need: *"You can't separate. . . . 'The spirit is twenty and emotion's forty-five, and the physical is this much."* Then Kate emphasized the importance of a nurse's interpersonal connecting manner in addressing spiritual need during physical care activities:

> *How I change the dressing has to do with meeting physical needs as well as the spiritual needs of the client. So it's how I conduct myself [that] . . . affects the spirit of others. . . . It opens the client up, and you can have a person-to-person exchange with a client as opposed to a task-oriented exchange.*

Thus, intraspiritual connection pertains to matters of physical, emotional, cognitive, and spiritual unity as well as the dynamics associated with an interpersonal, social, and mystical nature. Referring to the there-and-then interaction between her and the interviewer, Carol noted, *"We connect on a soul level; how, say, you and I are interacting. It's way more than just speaking. The best way I can describe it is an energy exchange."*

Building on the intra- and interpersonal aspects of living interconnection, the data also provide examples of transpersonal connection. Whereas intra- and interpersonal aspects pertain mainly to the here and now, transpersonal connection is evident when spiritual connection occurs beyond the limits of time and space. Often the participants described events of mystical knowing that occurred through circumstances that they believed that they were unknowingly destined to experience. Carol recalled that she *"had too many times in my life where people have appeared on my path, and I know it's not an accident because I've heard the exact right thing I needed to hear at that moment that has stopped me from making a poor choice."*

Similarly, from both personal and professional perspectives, several participants spoke of connecting with deceased or distant loved ones. Mavis observed:

> *When I am feeling sad or discomfort or disconnected somehow in my life, it is very comforting for me to call my [deceased] brother, . . . to just be with him. . . . It is very, very comforting. It is more comforting then talking to anyone about the sadness that I am feeling.*

Ina talked about a patient whose husband had recently died: *"He would come and visit her, and they would have conversations."* She emphasized the importance of nurses' being open to those kinds of spiritual experiences: *"You have some connection. . . . You're open to the fact that . . . he could come back and visit."* Noting that the client *"wasn't upset by it. There was no tears. . . . She was quite content . . . and comforted by it,"* Ina described the client's need to be reassured by the nurse: *"You must think I'm crazy."* Some participants admitted that earlier in their careers they would have been unprepared to recognize those kinds of transpersonal phenomena.

These nurses related other kinds of transpersonal connection to being guided by someone who was not present, sending healing energy through mindfulness techniques, and perceiving the experiences of another through body senses. For example, Dana reported that she sometimes connects with others from her past when a *"thought comes into your mind that is a help to get the right kind of nursing connection with this next challenge."* Kate and Lois used distant healing techniques with friends and family in need. Kate explained:

> *Part of the Reiki technique is the use of symbols and telegraphic symbols . . . for distance healing. . . . Either you bring the person to you . . . or you send the healing to them. . . . For instance, talk on the phone [or] do Reiki on their picture, and have the healing go to them.*

In addition to perceiving another's thoughts and projecting healing energy across time and space, Mavis sometimes connected and acquired interpersonal knowledge through other body senses: *"Sometimes what I experience are things that have happened to someone else. But they are in my body."* But, in general, the participants were often minimally aware of transpersonal spiritual connection. Speaking of the intra-, inter-, trans-, and extrapersonal connection associated with living interconnection, one patient in Hood Morris's (1995) study commented that nurses "as human beings were in touch with their own spirituality and maybe they weren't conscious" (pp. 75-76). He went on to explain the interconnected, often unconscious, nature of spiritual connection:

> don't think spirituality can be turned on and off with a switch; . . . there are moments/seconds when the spiritual part will kick in and take over and all they are is a physical vehicle to allow this spiritual energy to address other people's spiritual needs. . . . I think their spirits recognized the Creator. The Creator came to my room in the form of my spiritual family. . . . These [were the] nurses whose spirituality was turned on around where I was. (pp. 75-76)

As this man noted, nurses sometimes act as vehicles for connection with the Mystical Beyond. Many participants described feeling drawn to the Divine, receiving wisdom, and being interconnected in various ways and for various reasons. Some, such as Dana, spoke of being attentive to angelic guides: *"I need an angel sitting on my shoulder most of the time when I connect with them."* As a conduit for mystical healing, Ann emphasized the need for *"being* a presence *for a person."* She added, *"It's more than just a person being with another human being; . . . [it's] to be there, to be Christ's present, a presence with that person."* And described an incident early in her career when she had called for Divine assistance: *"I can't do this; I can't love this lady. You're going to have to* love her through me." Fran noted the importance of listening for and being "obedient *in my calling."* Similarly, Carol spoke of working with Divine energy: *"I connect with my Higher Power. . . . I get the energy from there, and it comes through me. . . . I'm more of a conduit."*

Overall, the participants expressed a consistent theme of interrelated spiritual connection as a way of living, whether they experienced events in their lives as good or bad, healthy or unhealthy. Kate explained:

> *You are still your spiritual being when you're closed. It is just that you're blocked, and you're not tapping into your fullness because you're living and being your fear. You see spirituality; it's not just a part. It's the open, it's the closed, it's the bad, it's the happy in everything.*

Thus to live interconnected spiritual connection means that it embraces all life experiences, all times and places. It requires intrapersonal, interpersonal, transpersonal, and extrapersonal aspects to unite in an interrelated, holistic, spiritual growth experience. It is all-encompassing and both timeless and spaceless. Bea summed up the notion of living interconnection: *"My spirit needs to be connected to people, to God, and connected with myself. If there isn't, . . . then . . . I don't believe that we can really nurse the whole person, because it is the spirit there that* desires *to be connected."*

Beneficent Reciprocity and Purpose: The How and the Why

The participants described living interconnection and then shed light on its how and why. Living interconnection occurs through a process of beneficent reciprocity. Recalling her favorite author, Carol explained her understanding of the reciprocal nature of living interconnection: *"We're all connected, and if I do something mean to you, I do it to myself, because we're connected."* Regardless of from which religious or nonreligious philosophy the participants drew guidance, they all acknowledged the growth-promoting living process of reciprocal taking and giving. The moral law of reciprocal beneficence was a universal guiding spiritual principle evident in all of the transcripts, and according to Kate, *"There's only one rule in Wicca, and it's, 'Do as you will, but harm none.' It's sort of like the Golden Rule: 'Do unto others as you would have them do unto you.'"* If aligning oneself with a Golden Rule is the way to live spiritually interconnected, then the next aspect addresses why living interconnected is important.

Linking her intrapersonal connection with interaction and helping, Elaine identified the reason for her choice of professional career: *"I think my spirituality"*—which she described as *"being interested in meaningful connections with other people, how I* carry *myself as a person, and how I act in my integrity"*—was *"one of the big reasons that I went into nursing."* Elaine referred to the opportunity to benefit another and emphasized the *"opportunity for interaction with people, . . . to be empathetic and to use that sense of connection . . . to help them through something."* Carol extended Elaine's expressed desire to connect to the broader purpose of fulfilling one's preordained destiny: *"I have to believe there's a greater meaning. I don't think I could do this work if I didn't believe that there was something else in charge. . . . It's our soul's evolution."* Others as well spoke of the spiritual purpose of living interconnection in an earthly experience. Nadine described a *"strong human spirit"* and noted, *"It is something very much internally a part of who and what you are, your belief, your thinking, your loving, your hate, whatever makes up you as the person."* Pointing to her body, she clarified, *"This is physical, but this dies. I don't think that other part does. . . . I believe that you have a life that you set yourself out prior to coming, and that you've got certain tasks that you have to learn."* Nadine added with regard to life objectives such as learning about tolerance, finding abundance within, and others, *"You still have free will though if you choose."* She clarified the purpose of her growing through various difficult experiences: *"That's why I'm saying that a lot of the experiences that I've had have kind of led from one to another, like a weaving, like a tapestry."*

Essence of Caring: Nurturing, Needing, Learning Connection

Caring has been commonly described as the essence of nursing. According to these data, it appears that living interconnection is the salient quality of professional caring. The basic social process of "connecting spiritually" weaves through the categories of nurturing connection, needing connection, and learning connection in the context of an interconnected life process. For instance, Elaine connected her personal spirituality with that of her clients and the nurturing and needing connection facets of the helping relationship: *"It is very hard for me to separate my own spirituality from others' and how I choose then to nurse those people or to be the nurse for them."* Similarly noting connection to all, Lois said:

> *The other thing that nurses do that could be attributed to spiritual care . . . is just the therapeutic use of self . . . .That means that . . . there is a spark of the Divine in all of us . . . channeled through a number of different ways. Sometimes it's denominational; sometimes not; sometimes it's just there. And part of the therapeutic use of self is using my spark to help a new light; . . . they are connected on a spiritual way to everybody else in the world, but also to a greater Divinity, however that concept is conceptualized.*

Thus, although not fully explicated, these data suggest that connecting spiritually through aspects of learning connection, nurturing connection, needing connection, and living interconnection represents the central phenomenon or essence of professional caring.

CHAPTER 5

CONNECTING SPIRITUALLY: THEORY AND DISCUSSION

A Theory of Connecting Spiritually: How Nurses Learn to Care for Spiritual Needs

From the data I derived a substantive theory of connecting spiritually to explain the process that practicing registered nurses use to acquire knowledge for spiritual care. Each participant recalled stories and related relevant current thoughts about significant personal and professional experiences regarding spirituality, spiritual needs, spiritual care, and the ways that they learned.

Central and salient in the data is the theme of connection, which appears as the core variable around which aspects of the theory unfold. Four distinct, yet intertwined categories of connection arose as parts of the process. Each category represents a specific perspective[4] related to the aspects of the research question. Living interconnection represents a spiritual way of being in life, needing connection addresses the perspective of the client, nurturing connection refers to the way that nurses care, and learning connection details the process through which nurses develop knowledge and skills for practice. To learn how to care for spiritual needs, nurses use a process of opening to, struggling with, and making connections between specific experiential events. Each experience pertains more or less to a featured perspective evident in one of the four categories. One categorical perspective is featured in the foreground of a given experience, and all the other categorical perspectives frame the background. That means that experience from a client perspective is connected to and framed by the experience of nursing, learning, and living. Experiences of learning are interwoven with and supported by experiences of living, needing, and nurturing connection. In other words, all perspectives give context to and provide support for the experience being described.

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[4] Here the term *perspective* means the point of view associated with a specific role and indicative of one of the four categories.

Not only does each category represent a specific perspective, but also the orientation of each perspective comes from either a position[5] of taking/receiving or a position of giving/responding. The process of learning occurs as a result of contrasting, complementary, and dialectic interchanges between take and give positions. Take and give positions and interactive processes occur between as well as within categories. Specific inner categorical processes associated with a series of mental postures[6] unfold in each category. Therefore, exchange of take and give positions, both between and within the categories, functions to move the learning along in an ever-advancing fashion over the course of a nurse's life and career. Thus, the basic social psychological process that practicing registered nurses use to learn to care for spiritual needs emerges as connecting spiritually—an interconnected, open process of shifting client-nurse learn-live perspectives, take-give positions, and mental postures grounded in cumulative experiential learning.

Figure 1 depicts a schematic diagram of the substantive theory of "Connecting Spiritually: How Nurses Learn to Care for Spiritual Needs." Each of the four categorical perspectives and their inner postural processes are featured and supportively framed by all of the perspectives from other categories. Through shifting between positions of take and give, needing connection interacts with nurturing connection. With an all-encompassing effort to actively open, struggle, connect, and experience, the basic social psychological process fosters learning connection and living interconnection.

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[5] Here the term *position* pertains to the role or function of one or the other contrasting, yet complementary opposites of take or give.

[6] Here the term *posture* refers to one of many intellectual, affective, or spiritual attitudes or conditions that are components of a particular process.

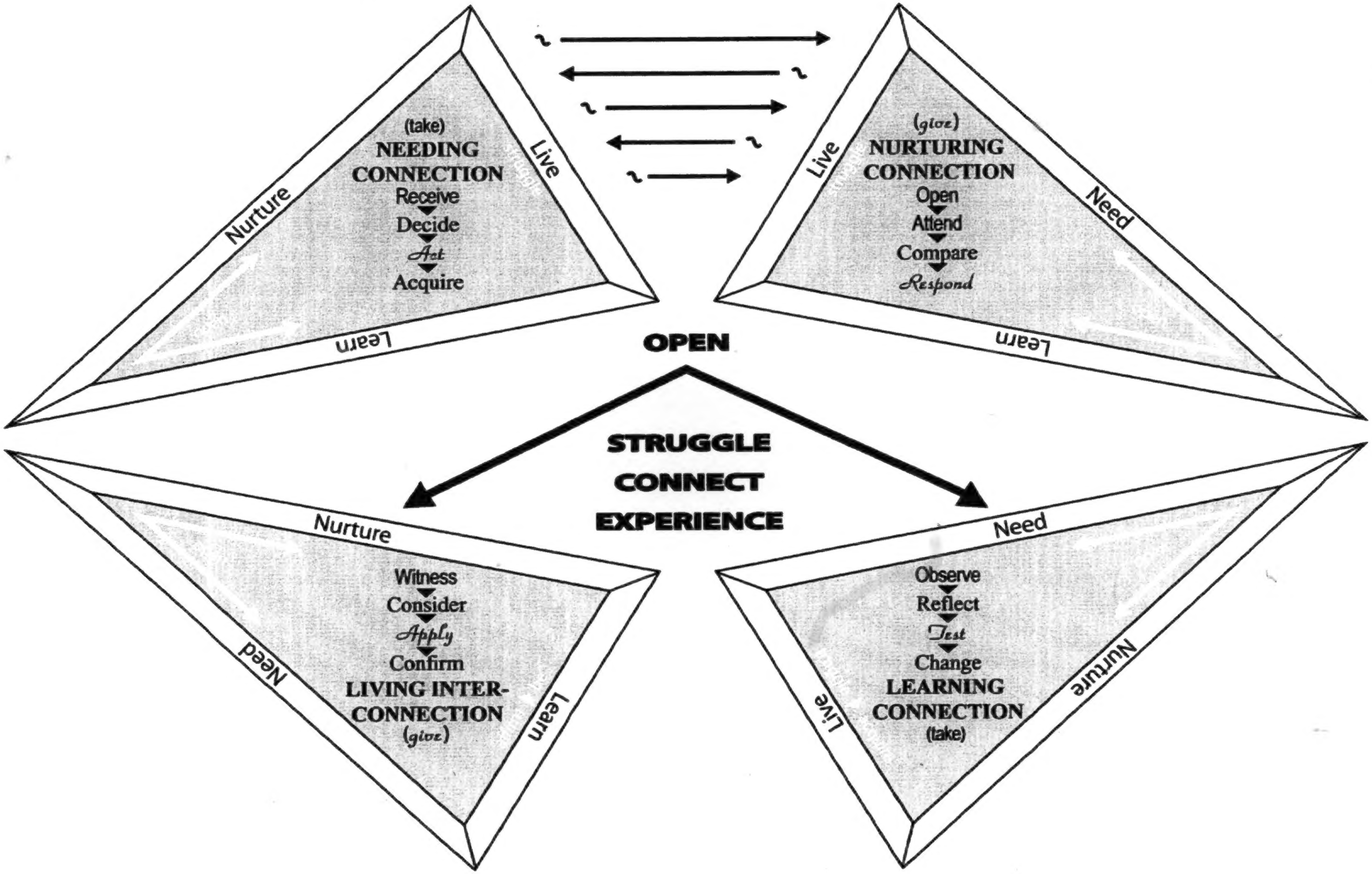
(take)
NEEDING CONNECTION
Receive
Decide
Act
Acquire
Nurture
Live
Learn
(give)
NURTURING CONNECTION
Open
Attend
Compare
Respond
Live
Need
Learn
OPEN
STRUGGLE
CONNECT
EXPERIENCE
Nurture
Witness
Consider
Apply
Confirm
LIVING INTER-CONNECTION
(give)
Need
Learn
Need
Observe
Reflect
Test
Change
LEARNING CONNECTION
(take)
Live
Nurture

Figure 1. Connecting spiritually.

Storyline Memo: Learning How to Care for Spiritual Needs

From the interpretive analysis of the participants' stories, I developed the salient themes and patterns into a fictional, yet representative storyline memo (see Appendix A). This narrative depicts the core variable, connection; the interrelated theoretical categories of learning connection, nurturing connection, needing connection, and living interconnection; their main properties; and the basic social psychological process of connecting spiritually. The nurse-narrator describes how she connected knowledge gained from numerous pivotal experiential learning episodes to learn how to care for spiritual needs over the course of a life and career.

Core, Categories, and Processes

The theory of connecting spiritually comprises a central phenomenon and a complex interaction between distinct categorical perspectives and inner processes that manifest into the basic social psychological process that registered nurses use in learning to care for spiritual needs. Using the interpreted storyline as a reference point, I detail below the fundamental components of this substantive theory.

Core Variable

The core variable *connection* appears everywhere in the data. With diverse and interrelated functions, connection serves to join the categories, their properties, and the fundamental process of learning. Some of the characteristics of connection manifest as presence and relatedness, giving and taking, listening and responding, being vulnerable and sharing personally, touching and praying, linking past with present and future experiences, being a conduit for mysterious energy, and making meaning and discovering purpose. In these characteristics are seen various indicators of connection as (a) a need from the client perspective, (b) an antecedent and an outcome to a nurse-client therapeutic relationship, (c) a caring state in a nurse manifesting true presence, (d) a consequence of both needing and learning, (e) an outcome of living spiritually, and (f) an integral process to join experiential learning episodes. Characteristics of connection are evident within and between categories. Awareness and level of connection range among nurses from unconscious not-knowing to mystical interconnected unity.

In the storyline the nurse-narrator described a specific path of interwoven episodes of needing connection, nurturing connection, learning connection, and living interconnection. Similarly, nurses learn how to care for spiritual needs through a process of connecting knowledge gleaned from various personal and professional experiences.

Categories

The action of opening to, struggling with, and connecting numerous experiences fosters the process of connecting spiritually. Experiences associated with connecting spiritually fall into four categories that represent four different perspectives, each of which is oriented from either a take or a give position. Within each category subprocesses occur with shifts between various mental postures. When one category is featured in the foreground, all other categories frame the background.

Living Interconnection

Interconnected with the needing, nurturing, and learning parts of the process of connecting spiritually is the category of living interconnection, which is predominantly about a way of being spiritual, guided by universal spiritual principles that interface and mingle with experiences of self, others, the world, and the Mystical Beyond. Living interconnection focuses more on a position of giving than of taking. Although rarely a featured experience in the stories of nurses, living interconnection always provides contextual support to other conceptual categories.

Early in the storyline when the needing, nurturing, and learning connection categories were featured, the narrator-nurse witnessed and considered interconnected spiritual components. These facets included losing and needing personal faith, as well as connecting in the present with a nurturing nurse, connecting in the past with her own experience of caregiving, connecting with God, and connecting to her future spiritual care activities as exemplified by the Golden Rule. Living interconnection is characterized by harmoniously balanced aspects of intrapersonal, interpersonal, transpersonal, and extrapersonal connection, as well as beneficent reciprocity, meaning, and purpose. In the storyline, threads of intrapersonal connection are evident when the nurse repeatedly struggled with a personal spiritual matter. Interpersonal connection is seen when the nurse recalled experiences of helping a client. Extrapersonal connection was demonstrated through the image of a guardian angel and when the nurse consciously gave troubling experiences to God. Transpersonal connection appeared when another nurse's healing presence connected outstanding spiritual issues with present circumstance and future practice. Along with witnessing and considering spiritual components, the nurse applied moral themes of the universal spiritual principle (Hood Morris, 1995, 1996) of reciprocal good. Pivotal events experienced in the journey of life provided the means to further explore and confirm notions of meaning and purpose.

Needing Connection

The needing connection category is predominantly about the perspective of a person in need of spiritual care. From the perspective of a nurse, connection in this category can arise from either the intrapersonal spiritual needs of the nurse or the assessed spiritual needs of the client. From the perspective of the recipient of nursing care, a client needs a nurse who is open, attentive, and responsive in order to connect. The position of the client from this perspective is focused more on passively receiving or actively taking care. Properties of needing connection include spiritual indicators, needs, and actions, as well as outcomes of spiritual care. An underlying process within this category unfolds in a causal-consequence fashion (Glaser, 1978) in which spiritual needs and their indicators are acted upon and, to varying extent, resolved through the development of knowledge, behavior, and/or belief. This process occurs through a sequence of mental postures: receive, decide, act, and acquire.

In the storyline the narrator recalled a personal traumatic surgical experience. Indicative of her spiritual need were memories of an unresolved tragedy, crying, seclusion, guilt, and a punishing belief of the Divine. Her spiritual need was to actively explain and explore the circumstances of her spiritual distress with a trustworthy, nonjudgmental, accepting, and responsive nurse. Risking her vulnerability, she accepted the nurse's offer and engaged in telling her perception of circumstance and truth. Integral to her perspective of needing connection was the nurturing, empathetic presence of the nurse and the resultant learning, growth, and resolution of spiritual distress. The narrator received and took the offer of a listening presence, engaged in exploration, acquired resolution of guilt, and then used her knowledge to change her practice.

Nurturing Connection

The nurturing connection category predominantly represents the perspective of a professional nurse engaged in client-centered therapeutic connection. The posture from this perspective is mainly about attentively responding to the expressed need of a client. Nurses give their attention in a fully present manner of being with the client in the process of working through their struggle. Through a client-centered oscillating inner-categorical process of assessment and intervention, nurses intentionally open to and actively take in information, compare and apply knowledge, and give feedback. The goals of this interactive dialectic process are for the nurse and the client to progressively come to a closer and closer understanding of the client's experience and for the client to discover some new insight, meaning, feeling, or action plan. Professional attributes of the nurse evident in the assessment phase of the nurturing connection category are caring, respecting, and empathizing; being open, nonjudgmental, and client-centered; listening, exploring, questioning, and being there; and checking, making time, and following through. Properties associated with intervening include touching, embracing, and enabling self-control; supporting, reconnecting, and referring; and sharing personal knowledge, being God's conduit, and creating an environment for religious practices.

In the storyline the narrator described her attentive opening, mental comparison, and later application. These behaviors are postures associated with the process of nurturing connection. She noted the accepting, nonjudgmental, fully present, physical, and empathic response of a nurse. As well she explained how, in the span of only a few minutes, the experience of being truly heard and then connected to the experience of others in similar circumstances fostered new meaning, self-forgiveness, and intrapersonal unity. Furthermore, this experience of nurturing, of connecting therapeutically through true presence, led to professional learning, enhanced understanding and beliefs, and change in nursing practice.

Learning Connection

As demonstrated, learning is most often an outcome of both needing and nurturing connection. Building on experiences with needing and nurturing connection, the learning connection category is predominantly about the experiential process that nurses use to acquire knowledge for spiritual care. As in the needing connection category, the position assumed in the learning connection category pertains mainly to needing, taking, and/or receiving knowledge. Moreover, as in the reciprocal internal take-give process evident in the nurturing connection category, an aspect of giving is also evident when nurses test knowledge in the learning connection category. Some properties of the learning connection category include an inner process of observing, reflecting, and testing experiences of spiritual care. Other characteristics include receiving instruction, spiritual care, and mystical intuition. Through the process of learning to care for spiritual needs, changes in knowledge and practice occur. In particular, various personal beliefs, beliefs about clients, and sometimes religious beliefs are expanded or modified. In turn, the nurses reported an increased ability to protect themselves from the adverse effects of their work. They learned to shift their practice orientation from an edict to fix to an ethic of facilitation.

In the storyline, learning connection was front and center when the narrator changed her practice to include a deliberate invitation to exploring, careful listening, nonjudgmental openness, and the sharing of personal knowledge. She did not feel compelled to supply answers or suggest actions for her clients. Instead, she focused on taking in their concerns and giving back what she understood, thereby helping clients to find their own meaning. Later the narrator explained that, as she learned to care for her clients and her own spiritual needs, she changed her basic beliefs about the purpose of life. Finally, the narrator recognized the ongoing multifaceted, stepwise advancement in her learning process.

Evidence and outcomes of the learning process range from unconsciously attending to spiritual needs, to deliberate avoidance, to testing efficacious spiritual care interventions. The time that it takes to progress towards expert spiritual care practices also varies. What is clear is that registered nurses in direct clinical practice progressively evolve in their ability to care for spiritual needs during their careers.

Connecting Spiritually: The Basic Social Psychological Process

With the core variable and the four categories, their characteristics, properties, and inner processes addressed, what remains to be explained is the basic social psychological process that practicing registered nurses use to learn how to care for spiritual needs. Nurses face a problem of how to acquire knowledge for spiritual care. Parts of the problem include determining what spirituality means, what spiritual needs are, and what strategies are useful for addressing those needs. Each one of these questions emerges as a separate theoretical category and is joined through the core variable of connection. Based on numerous personal and professional episodes of experience, categorical perspectives interrelate in an all-encompassing basic social psychological process that unfolds as open, struggle, connect, and experience.

The orientation within each category comes mainly from either a taking/receiving or a giving/responding position. Rhythmic oscillating shifts back and forth between taking and giving fuel the learning process.

As the nurses in this study gave details of how they learned, they referred to various discrete episodes of personal and professional experience. Each episode of experience covered a period of time with significant meaning-making moments in that period. Each experiential period pertains predominantly to one of the theoretical categories and features the specific perspective emanating from that category.

The first category evident in the storyline was learning connection. It pertains to a period of time early in the nurse-narrator's career when she was struggling with learning about spiritual care. The perspective and main feature of this episode of experience was how to gain knowledge and acquire skills appropriate for addressing spiritual needs. The main position was oriented toward receiving or taking in needed information. However, part of this featured experience included moments or pieces of perspectives represented in the other three categories. Focusing on explaining the beginnings of her learning, the narrator also included moments of expressed client need, her tenuous efforts to nurture, and her surprise at the development of a meaningful connection.

In every period of experience, moment-to-moment perspectives from all of the categories act as a frame to support and give context to the featured perspective. Therefore, featured perspectives are framed, interwoven, and connected with perspectives from the other categories.

Similar to the rhythmic take-give exchanges occurring between categories, shifts between the various positions also manifest in a variety of inner processes within each category. Inner processes usually start from a position of taking that manifest in actions such as observing, listening, or witnessing. Whatever is received is then considered as the person shifts to a position of giving. Giving positions appear as responding, testing, or acquiring. These inner processes oscillate many times between take and give positions as the problem or need is worked through.

The needing connection inner process generally appears as receive, decide, act, and acquire. In the storyline the narrator (from her perspective as a patient) received an invitation to talk, decided to trust, acted by revealing and mutually exploring the roots of her need, and acquired meaningful insight and the resolution of her guilt.

The nurturing connection inner process most commonly develops as opening, attending, comparing, and responding. The narrator described a nurse opening with nonjudgmental and careful attention to her physically and psychologically expressed need. Comparing the story to experiences that the nurse witnessed with others, she then empathically offered a client-centered meaning-making response.

The learning connection inner process unfolds as observe, reflect, test, and change. The nurse-narrator in the storyline observed the spiritual care practice of another nurse, reflected on her own experiences of having and nurturing spiritual needs, realized that she did not need to have a right answer, contemplated the efficacy of sharing her personal knowledge with clients, and tested her theory through sensitively and anonymously sharing relevant stories from others. Her beliefs and practices changed from blaming to finding, or helping another to find, meaning and purpose.

The living interconnection inner process often manifests as witness, consider, apply, and confirm. Through numerous experiences of witnessing the results of need-nurture interchanges, the nurses in this study, like the narrator, considered and applied acquired knowledge and efficacious practices. Guided by the Golden Rule, the helpful actions of the nurse-narrator were then confirmed when past experiences were connected to current and future need-nurture events. Not only were experiences linked through time, but experiences of living interconnection also involved meaningful growth within the nurse-narrator and between her and others. Later in the storyline the nurse-narrator related how connection with God and other mystical figures had helped her both personally and professionally.

Therefore, categories and their properties are connected through a dynamic process of shifting perspectives and oscillating positions and postures. Needing connection and nurturing connection interweave back and forth in an ever-tightening and connected take-and-give process that culminates in relational understanding. In order to progress with learning how to care for spiritual needs, nurses require these contextual experiences of needing and nurturing connection. Through an all-encompassing basic social psychological process of opening, struggling, connecting, and experiencing, nurses learn to care for spiritual needs. In a sense, learning and living connection develop into the outcomes of needing and nurturing connection. Learning is therefore the product of the shifting relational process of needing and nurturing. Over the course of nurses' lives and careers, the fundamental learning process unfolds as nurses open to, struggle with, shift between, and connect the various perspectives, positions, and postures associated with different experiences of living, needing, nurturing, and learning connection. Connecting spiritually emerges as the basic social psychological process that nurses use to learn how to care for spiritual needs.

Discussion

In preparation for this investigation into how it was that practicing registered nurses learned the knowledge and skills necessary to care for spiritual needs, I needed to work through any issues that may have biased the interpretation. First, because I was (and am) still growing in my understanding of spirituality, spiritual care, and the ways that I learn, I wondered whether others would have trouble knowing and articulating responses to my questions. I knew from the literature that a great deal of confusion exists between the concepts of religion and spirituality, and I wondered how I could phrase my questions so I would get answers about spiritual needs and care that did not originate exclusively from a religious perspective. This premise was evidence of an underlying assumption that religion and spirituality were somehow different and that data from a religious perspective would not fully answer the research question. I needed to refrain from allowing my biases to foster preconditions and to discovering whatever it was that my participants thought, felt, and experienced. I needed to open myself to the possibility of hearing a religion-based expression of spiritual need and care.

Another initial concern pertained to how I would find the best participants. Part of me reflected on whether or not the results would indicate best nursing practice, the "right" way to learn, know, and care for spiritual needs. But I realized that the findings from this study were not about what was right or wrong with spiritual care nursing practices. Specifically, for that matter, the intent of the study was not particularly about describing spiritual care, but rather it was about discovering a process of learning. This study was about what was actually happening for my participants as they learned about caring for spiritual needs. To discover the process that nurses use to learn, I needed a broad range of nurse participants who could tell me their stories and thoughts about specific questions related to the unfolding theory.

Along the way other issues arose as I constantly compared and questioned the data. As I discuss the findings and the theory, I will explore some of the relevant questions and issues that appeared through the interpretation process. To do this I will compare and contrast other relevant scholarly work in order to show how this theory, its categories, and its properties fit within a broader body of literature. I will start by exploring some of the parameters of the basic social psychological process, followed by aspects pertaining to the categories, and finally focus on discussing the core variable, connection.

Shifting Perspectives, Positions, and Postures: The Means for Connecting Spiritually Through Experiential Learning

While I analyzed the data, it became clear that the study was mainly about an all-encompassing process of learning; yet it was also about inner processes related to spirituality, spiritual needs, and spiritual care. I wondered how these processes influenced each other. How did they compare with other types of human health and learning processes? I wondered what mechanisms enabled these processes to unfold. Were the trajectories more circular or linear? Did they proceed like a shuttlecock (back and forth), or a ratchet (one step backward, two forward), or some other way?

Some nurse-scholars have argued that notions of spirituality and nursing care are about an organic, holistic, circular, and intuitive experience that does not lend itself to the idea of learning gained in a linear growth process (Burkhardt & Nagai-Jacobson, 2002;

Mohnkern, 1992). Parse (1998), for one, rejected the stepwise progression associated with the nursing process in favor of the notion of a synchronizing, rhythmic dwelling with presence, with a flow of connecting and separating. Others conceived spirituality and nursing care as a journey with specific stages and components of interaction and learning. However, whether conceived of as a subtle movement within a river-like holistic flow or the take-give positioning associated with a tide-like interaction, "within all human experience, we find the juxtaposition of contrast, of complementary opposites—joy and sadness, hot and cold, light and dark, yin and yang, feminine and masculine" (Burkhardt & Nagai-Jacobson, 2002, p. 14). Although others have noted the influence of shifting perspectives (Kuiper & Pesut, 2004; Paterson, 2001), positions, and postures, previous work has not adequately explained the function of this interactive process. Some have recommended the need for balance between opposites. But in this study it was within and among these interacting shifts of take and give positions where the learning occurred.

Often, notions of take and give are connected to other concepts, and together they imply an action of doing something. For instance, common language implies a doing, action-orientated intent of well-being with salutations such as "Take care," "Take heed," or "Give up." But these actions are more about describing the what of an action than the how of a process. Describing the concept of confirmation, Halvarsson and Johansson (2000) associated giving and receiving with a process-oriented model of nursing supervision. However, the properties take and give were not identified as mechanisms of the process. Instead, based on either a learner/nurse or a teacher/supervisor perspective, they were used to indicate the direction of a linear model to encourage the use of confirming behaviors. Notions of give or take are more often used simply to qualify other concepts. In the current research, however, the functions of taking and giving and the shifting between various perspectives and postures were central to how a process happened. Instead of just qualifying the 'what' of another concept, take and give functioned to emulate the 'how' of various processes.

Every category contained an inner process of shifting between positions of take and give, which were tied to the various attitudinal postures. From the perspective of a recipient of spiritual care in needing connection, a position of taking connection preceded and was balanced with a posture of acquiring meaning, knowledge, or comfort. A take position also manifested in nurturing connection as the nurses opened with client-centered attention. The position of taking in clients' circumstances was reciprocated with a position of giving an empathic response. Learning connection fostered a taking position associated with the posture of observing that was balanced and reciprocated with the position of giving through testing. Shifts between take and give positions were mediated with postures of consideration, comparison, or reflection. Similar to the interplay between postures within categories of the current research, Kuiper and Pesut (2004) proposed a model of shifting perspectives of clinical reasoning that included an interchange between cognitive thinking skills and metacognitive reflection. Properties of metacognition included careful consideration and examination of personal and professional life experiences in the context of enacting self-monitoring, evaluating, reinforcing, and goal-orientated behaviors. Properties of the cognitive thinking skills associated with clinical judgment included discerning patient care problems, issues, and diagnoses; contemplating care; and making decisions that gave meaning to and a sense of evidence for changes in patients' states of health (Pesut, 2001). Depending on the need and learning context, various postures that were associated with metacognitive reflection and "critical, creative and systems thinking" (Kuiper & Pesut, 2004, p. 389) shifted between the background and the foreground of clinical reasoning (Pesut, 2001). However, although both metacognitive and critical thinking perspectives were proposed to be important to the development of clinical knowledge, Kuiper and Pesut (2004) implied that either one or the other learning method takes precedence at any given time. Unlike in the current research, there was no indication of a specific connected and interacting mechanism that was occurring between the two postures.

Contrasting positions were also directly associated with the perspective of each of the four categories. Needing connection and learning connection were more about a position of taking, whereas nurturing connection and living interconnection pertained more to a position of giving. The shifting between take and give positions associated various cognitive-attitudinal-affective postures, and categorical perspectives drove the learning process. In this study, shifting from one position, posture, or perspective was the mechanism of the basic social psychological process of connecting spiritually.

As stated, along with an inner-process of shifting between take and give positions and postures, each theoretical category detailed a specific conceptual perspectives pertaining to the research question. The perspective of the recipient of spiritual care was featured in the needing connection, the perspective of nurses was featured in the nurturing connection, the perspective of learning how to care for spiritual needs was featured in the learning connection, and the perspective of being spiritual was featured in the living interconnection. Over the course of the research participants' careers, different perspectives became featured in numerous distinct experiential events. Similar to the mechanism of shifting between inner positions and postures, shifting between perspectives also occurred. When one experience featured a particular perspective, perspectives from other experiences contrasted and complemented the experience in the here and now. For these nurses the process of learning was analogous in many ways to the process of growth and transformation that their clients experienced as they adjusted to changing health patterns. Both perspectives came from a position of taking in needed information or care.

Traditional models of the characteristics and trajectory of chronic illness have suggested that people progress through a disease process in a linear and phased fashion. Researchers at the University of British Columbia disputed the notion of a predictable, straightforward line of chronic illness experience. In comparison to earlier models, the shifting perspectives model indicated that living with chronic illness is an ongoing and continually shifting process that oscillates between either "an illness-in-the-foreground or the wellness-in-the-foreground perspective" (Paterson, 2001, p. 21). Like the learning achieved by the nurses in the current study, persons with chronic illness in Paterson's study experienced "a complex dialectic between themselves and their 'world' . . . [that enabled them] to make sense of their experience" (p. 23). Each perspective contained distinct beliefs, perceptions, expectations, and attitudes about what the particular perspective meant. These ideas were paired with a contrasting background perspective. Shifting in degree at any given time, either the illness or the wellness perspective took precedence as the reality of the disease process and the personal and social contexts changed. In the shifting perspectives model, perspectives, not reality itself, determined how people responded. In comparison, the perspectives in the current research were integral to the whole learning process. The shifts and comparisons in the perspectives, not one or another specific perspective, were the actual mechanism of learning. When one perspective was more prominent in the foreground, all other perspectives lent contextual support from the background. In other words, all perspectives framed the featured perspective.

Paterson (2003) suggested that every person with chronic illness has a preferred perspective. However, this finding drew criticism from a key informant[7] who believed that it indicates a bias towards a wellness perspective. The woman feared that by favoring a wellness perspective, the potential learning from the process of struggling when illness was in the foreground would be thwarted. Indeed in a related study, Paterson, Thorne, Crawford, and Tarko (1999) suggested that the transformation of persons experiencing diabetes was a not sequential process, but that it had plateaus, peaks, and retreats. They concluded that the process and, in particular, the individual's experience in the process were the featured perspectives associated with transformation. Like the learning of nurses in the current research, transformation was found to be a never-ending process that always resulted in significant change (Paterson et al., 1999). Learning in the theory of connecting spiritually occurred through the shifting and connecting of significant pivotal experiences, like a ratchet, with neutral, reflective, and engaged phases, but always in a forward motion.

Experiential Learning

The next question that I had pertains to how the process of learning that the nurses in the current study used compared with other models of learning. To review, the basic social psychological process that they used to learn to care for spiritual needs was to actively open, struggle, connect, and experience. In other words, the basic learning process of connecting spiritually unfolded as a sequence of connecting various relevant life experiences through opening and struggling. Theories of experiential learning have been proposed by several social, educational, and nursing scientists (Benner, 1984; Hunt, 1987; Kolb; 1975, 1984; Taylor, 1979, 1987). In this research, theoretical knowledge associated with formal education pertained to only one of the types of experiences.

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[7] A professionally educated woman with chronic illness.

However, most knowledge for spiritual care is acquired from struggling with a variety of other types of personal and practical learning experiences.

Building on the traditions of Lewin, Dewey, and Piaget, Kolb (1984) proposed a model of experiential learning from the perspective of an individual learner. Kolb (1975, 1984) described a cyclical learning process with stages of (a) having a concrete experience in the here and now; (b) collecting data, making observations, and reflecting; (c) analyzing and forming abstract concepts and generalizations; and (d) testing or experimenting with the implications of these concepts in new situations. In comparison with the findings from the current research, the process that Kolb described best fits with the inner categorical properties of learning connection: observing, reflecting, contemplating, and testing. However, unlike the processes evident in learning connection and the theory of connecting spiritually, there was no specific mention of intentionally opening or cognitively and emotionally struggling through pivotal experiential events.

Hunt (1987), another experiential learning theorist, extended Kolb's (1984) theory and applied it to the learning that occurs because of an interaction between two people. Hunt (1987) conceived a relational process of sequencing cycles that parallels Kolb's (1975, 1984) stages of experiential learning. Person 1 would proceed from feedback to perception, to implicit theory, to intention, and to action; followed by person 2, who would proceed from feedback to perception, to implicit theory, to intention, to action; the process would then repeat back to person 1. Hunt's linearly constructed and interacting cycles of facilitator and learner dialogue would apply to some extent to here-and-now helping relationships that occurred between the nurses and patients in the current research. However, whereas the components of the learning cycle are evident in the current research, the helping process associated with the true presence found in the theory of connecting spiritually manifested in a much more intertwined manner. Nurses and clients engaged in simultaneous, sequential, synchronized, yet transpersonal processes of needing, nurturing, living, and learning. At the micro level in a here-and-now transaction, both the nurse and the client joined in a mingling of experience and exchanged moment-to-moment postures that were akin to the learning components described by Kolb (1975, 1984) and Hunt (1987). Neither theorist explained the function of shifting between the take and give positions that were imbedded in the learning processes of the current research.

Hunt (1987) briefly mentioned a "feeling mode" (p. 151) as a way for a learner to intentionally trigger the initial concrete experience of the learning cycle. There were no other affective behavioral indicators (such as the confusion, crying, or uncertainty associated with the posture of struggle in the current research) apparent in either Kolb's (1965, 1984) or Hunt's learning models. However, cognitive behavioral indicators were more evident. Kolb (1984) described the stage of abstract conceptualization, and Hunt added the notion of a learner's developing an implicit theory about the concern at hand.

The learning processes that both Kolb (1984) and Hunt (1987) described appear to pertain more to short-term learning episodes than to the longer cycles of learning linked with the development of an expert practice over a nurse's career. Both theorists proposed that the cyclical process of learning proceed in only one direction, but that, at times, some learners bypass certain phases (Mackeracher, 1996). They expounded on several specific types of learners: diverger, assimilator, converger, and accommodator. According to Kolb, with each style of learner, one or more phases of the learning cycle are skipped, but the processes of acquiring knowledge are still unidirectional. Hunt suggested that cyclical steps are included in all human-to-human interactions, but that "most interpersonal transactions take place in a split-second cycle . . . with no awareness of perception or intention" (p. 147). The current study indicates that the nurses learning to care for spiritual needs also progressed in an ever-advancing manner of acquiring knowledge. However, the current study is not detailed enough to determine the evidence or consequences of nurses skipping certain micro components of the learning process. This may be because the learning process discovered in this study pertains to retrospectively narrated data that covered a much longer period than the data collected for shorter-term learning experiences. The participants in the current study recalled and connected numerous pivotal learning experiences in an effort to bring together the various perspectives and explain a broad process of learning about spiritual care. They generally did not focus on the moment-to-moment details of the learning process associated with each event. Instead, they drew on a number of detailed descriptions of spiritual need and spiritual care to show the process of learning over time. The nurses described an overall sequential, yet complex and shifting, learning process that included all seminal components of the theory of connecting spiritually: opening, struggling, and connecting experience.

In a longitudinal study among a group of graduate students engaged in self-directed learning over one semester, Taylor (1979) also found a sequential cycle of learning and initially described the learning process as having four phases:

> detachment (related to people, events and ideas through an existing perspective and preconceptions); divergence (collapse of the perspective into confusion and disorientation); engagement (an intuitive exploration, direct involvement with people, event and ideas, gathering of insights); and convergence (a major synthesis, a novel understanding which is also put into action). (p. 10)

Taylor (1987) then modified and further explained her theory, noting affective aspects of a disorientation phase including confusion, loss of confidence, anxiety, withdrawal, and denial. These types of behavioral responses occur before a learner proceeds through other newly modified phases of exploration, reorientation, and equilibrium. Along with cognitive and interpersonal shifts in attitude and behavior, these affective characteristics may indicate some emotional and intellectual tension associated with the learning process. However, the concept of struggle, found to be integral to the current study, was not made explicit in Taylor's model. Although Taylor's (1979, 1987) model draws on different experiences that occur over time, the stages of this learning process were analogous to the shorter here-and-now learning processes proposed by Kolb (1984) and Hunt (1987). All three authors focused on the use of experiences to fuel the learning process. The notion of connecting experiences and components of experiences in the process of acquiring knowledge were implicit in all models. However, the idea of engaging in a take-and-give struggle of thoughts and actions was much less evident. Moreover, none of the models described so far explicated the initial step of opening to the events, ideas, and meanings associated with the learning process. Table 1 compares the similarities and differences between the phases of the learning processes of these cyclical models of experiential learning with those discussed in the findings of the current research.

Another experiential learning model pertained directly to the stages of learning achieved over an extended period with nurses working in direct clinical practice. Authors

Table 1

Comparison: Cyclical Experiential Learning Models

Aspect	Kolb (1984, p. 21)	Hunt (1987, p. 156)	Taylor (1979, p. 10)	Taylor (1987, p. 187)	Hood (current)
Method	(Deductive theory) Adapted from Lewin	(Deductive theory) Adapted from Kolb	Qualitative design Sequenced weekly interviews, participant observation		Grounded theory
Type of learners studied	One learner	Facilitator & learner	Grad student in learning group		Practicing RN
Period of time	Present	Present	Over one semester		Retrospective
Substantive focus	Lewinian experiential learning model	Interpersonal relations experiential learning model	Adult learning in an emergent learning group	Self-directed learning model	Connecting spiritually
Phases:					Experience Open
Cyclical learning process	Concrete experience	Feedback	Detachment divergence	Disorientation	Open Struggle
	Observations & reflections	Perception	Engagement	Exploration	Struggle
	Formation of abstract concepts & generalizations	Implicit theory & intention	Engagement Convergence	Exploration	Struggle Connect
	Testing conceptual implications in new situations	Action	Convergence	Reorientation	Connect
				Equilibrium	Connect Experience

associated with Benner's (1984) ongoing program of research have explored the characteristics and integration of theoretical nursing knowledge with practical experience. Benner distinguished key attributes indicative of each of five stages of the progression from novice to expert nursing practice. This seminal nursing model of experiential practice-based learning focuses on identifying meanings, content (Benner, 1984), competency, and skill-acquisition (after Dreyfus & Dreyfus, 1980), and not on discovering theoretical terms as with a grounded theory methodology (Benner, 1984). The intent was more to describe what comprises the phases instead of how they happen. However, the unfolding process of learning was evident, but manifested somewhat differently than in the models previously described. Sequential, but not necessarily cyclical, stages of learning included novice, advanced beginner, competence, proficient, and expert (Benner, 1984; Benner, Tanner, & Chesla, 1996; Dreyfus & Dreyfus, 1996).

The stage of novice is characterized by a learner's acquisition of theory-based knowledge and context-free "rules for drawing conclusions or for determining actions" (Dreyfus & Dreyfus, 1996, p. 37). The stage of novice parallels the task-oriented expectation of certain rules and procedures and the cautious, less deliberative approach to practice that was indicative of the beginning stage of nurses learning to care for spiritual needs in the current research. In Benner and colleagues' research with nurses (Benner, 1994a; Benner & Wrubel, 1989) in critical care practice situations (Benner et al., 1996), they found that during the novice stage nurse-learners required explicit rule-based formal theory to guide practice. In comparison, most nurses in the current study were unable to identify any specific theory-based nursing instruction that provided rules to apply to spiritual care situations. In most instances, the participants in the current study relied extensively on personal and some professional experiences to inform their spiritual care practices. Dreyfus and Dreyfus stated that "only after the novice has considerable experience coping with real situations" (p. 38) does performance improve to a marginally acceptable level. They said that only with combined situational experiences did a nurse at an advanced beginner stage start to recognize intuitively[8] relevant elements in a broader conceptualization of a current situational need. In other words, similar to how participants in the current study told stories of building knowledge through observations, reflections, and testing spiritual care practices that occurred with previous experiences, the nurses in Benner's research drew extensively on situational experiences for ongoing learning.

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[8] Authors associated with Benner's work defined *intuition* as an ability that results from a physiological brain process in the context of having had situational experience, and not from "wild guessing nor supernatural inspiration" (Dreyfus & Dreyfus, 1996, p. 38).

The competence stage (Dreyfus & Dreyfus, 1996) is characterized by an overwhelming number of relevant situation-specific elements that cause the learner to be nerve-wracked and exhausted. Priority of importance is not apparent prior to the competence stage. The competent practitioner develops a hierarchical perspective and devises new rules and reasoning procedures. Through taking on great responsibility and without knowing the outcomes of their choices, practitioners experience fluctuating fear and elation as the course of their interventions is carried out. Emotional engagement begins to occur, and vivid memories are formed that support future practice choices. Dreyfus and Dreyfus explained that, for the learner in the competent stage, "it becomes increasingly difficult to draw back and to adopt the detached rule-following stance of the beginner" (p. 40). This wrestling of choice of perspective, goal, or action parallels the struggle noted in the theory of connecting spiritually. Through connecting direct experience, the participants in the current study discerned guidance for the best spiritual care practices.

At the stage of proficiency, synaptic brain changes occur because of learning from both positive and negative experiences. The practitioner's original reliance on rule-driven theory is gradually replaced by brain-synapse-produced situational discriminations that are accompanied by relevant responses. Dreyfus and Dreyfus (1996) contended that proficiency develops only if experience is incorporated in an atheoretical way. In the current research, most of the learning occurred because of serendipitous experiential learning without the benefit of formal theoretical education. Similar to what Benner (1994a) described, past experience became constitutive of future practice, and new understandings sustained connection and confidence in caring practices. Finally, based on practiced situational discrimination at the stage of expert, the practitioner knows both what to do and how to do it. The expert practitioner relies less on rules in order to apply theory to practice. However, in new, unfamiliar practice situations where intuitive ability has not been developed, reasoning helps to guide decisions. But the inferential reasoning, or *calculative rationality*, found in the stages of novice, advanced beginner, and competent practitioner are replaced by a *deliberative rationality*. Dreyfus and Dreyfus explained:

> Deliberative rationality stands out at the intersection of theory and practice. It is detached, reasoned observation of one's intuitive, practice-based behavior with an eye to challenging, and perhaps improving, intuition without replacing it by the purely theory-based action of the novice, advanced beginner, or competent performer. (pp. 43-44)

This often leads the practitioner to a completely new perspective. In the current research many seasoned nurses gave examples of how this kind of conceptual rendering fostered changes in beliefs and practices because of being open to and challenging certain routine nursing ways of thinking and doing. As the nurses told their stories of what constituted and sustained their practice of spiritual care, new understandings arose that connected, reinforced, and sustained rationale for future practice skills.

Rubin (1996) found that, without experientially developed skills of emotional engagement that are balanced between attentiveness and over involvement, the nurses in her study did not become expert practitioners. Emotional engagement as well as other relational virtues such as openness, attunement, and responsiveness (Benner, 1994b, 1997) were required attributes for expert nursing practice aimed at "a respectful meeting of the other" (p. 48). Attributes found in and between the nurturing connection and needing connection categories of the current research demonstrated the client-centered, balanced, attuned, responsive, and engaged take and give transaction analogous to Benner's description of the stage of expert nursing practice.

Presence: The What and the How of Spiritual Care

As I worked with the data, I knew that part of the research question pertained not only to how nurses learn, but also to what their spiritual care practices are. As the category of nurturing connection began to emerge, I wondered how the characteristics of this kind of nursing care compared with other nursing practices. I found that connection from the perspective of nurses doing their work came in the form of a therapeutic presence. I recalled how impressed I had been by the quality of the consensually validated nursing care interventions associated with the diagnosis of spiritual distress (Wesorick, 1995). I wondered how those findings fit with current descriptions of spiritual care and other descriptions of presence in the literature.

With a broad sample of expert nurses working in direct clinical practice, Wesorick (1995) evaluated, refined, and recommended spiritual care interventions that were quite consistent with ways that the nurses in the current study assessed, intervened, and cared for spiritual needs. Guidance to create a private/safe environment, facilitate exploration, develop trust/rapport through presence/empathy/sensitivity, and mutually determine a spiritual care method (Wesorick, 1995) parallels many of the properties in the current research such as caring, walking/sitting with, provoking thought, supporting, reconnecting, and creating an environment for spiritual practices.

Wesorick (1995) used the term *presence* in a way that implies a method that a nurse would use in a care situation. Similarly, Paterson and Zderad (1976) described presence as a quality of self that one freely gives to another. However, the current research indicates that presence is more than a one-way gift of focused attention. Presence requires an active opening to, joining, taking, giving, and mingling with another. Hines (1992) identified the idea of presence as a state of being with another. Presence with others reflects a whole-person exchange, an intersubjective dialogue between two persons transacting, valuing, connecting, and remembering (Hines, 1992). In the current research the perspective of the nurse is connected to the perspective of the client in a mutually explorative and enriching presence. Intertwined with needing connection, presence pertains to both the nature of nurturing connection and the process of connecting therapeutically.

McKivergin and Daubenmire (1994; as cited in Watson, 1999) explained three levels of presence. Physical presence pertains to "being there" in the close proximity of routine care through seeing, touching, doing, or carefully listening. Psychological presence is "being with" another in a "mind-to-mind connection [through using] basic helping relationship and communication skills" (p. 226). Therapeutic presence is aligned with the notions of a caring consciousness, mindfulness, and intentionality, which Watson (1988, 1999) explained in her model of transpersonal caring. Similarly, presence in the current research is connected to mutual growth and learning experiences that occur as a result of near-simultaneous, moment-to-moment shifts and exchanges of positions, postures, and perspectives. Watson (1988) explained the joining of phenomenal fields[9] (subjective realities or frames of reference) of both nurse and client in the past-present-future mingling of thoughts and feelings during an "actual caring occasion" (pp. 58-61). She said that as a result of transpersonal caring, "the presence of the *geist* or spirit of both . . . expands the limits of openness . . . and human capacities" (p. 59). Hines (1992) found that the attributes of presence include connectedness (a process of being vulnerable, hospitable, engaged, and sharing intersubjectively) and a sustaining memory that blends past, present, and future and leaves a significant impression. Intersubjective sharing fosters learning from one another about how to be human. This learning includes knowledge of self, others, and the universe (Watson, 1988). Therefore, presence is not only a state of being with self, another, and the Mystical Beyond, but also an action of therapeutic caring connection.

With regard to true presence, Parse (1998) detailed how to live the art of human becoming. Like Watson (1988, 1999), and consistent with the current findings, Parse explained, "Quality of life as the incarnation of lived experiences is the indivisible human's view on living moment to moment as the changing patterns of shifting perspectives weave the fabric of life through the human-universe interconnectedness" (Parse, 1994, p. 17). Unlike Watson (1988, 1999), whose model of transpersonal caring stems from a spiritual perspective, Parse did not specifically explore the notions of spirituality, spiritual needs, or spiritual care. However, Parse's description of "quality of life" could be interpreted as "spiritual well-being." Apparent in this description, Parse (1998) shared a great deal in common with the perspectives of clients and nurses in needing connection and nurturing connection, as well as aspects of learning connection and living interconnection. Moreover, the process of connecting spiritually through shifting perspectives clearly can be seen.

Parse (1998) described the actions of a nurse guided by an ethic of true presence that are consistent with the properties associated with assessing spiritual needs and intervening spiritually and mystically in nurturing connection:

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[9] Influenced by Carl Rogers, Kurt Lewin, and Eastern psychology (Watson, 1988).

> The human becoming nurse's goal is to be truly present with people as they enhance their quality of life. . . . The nurse, with the person, family, or community, invites a discussion of the meaning of the situation. . . . Articulation of such thoughts connected with the moment in the presence of the nurse may surface with *ah-has*, which are ways of viewing the familiar in a new light. The nurse stays with persons as they describe the ups and downs, struggles, moments of joy, and the unevenness of day-to-day living in the now moment. The nurse . . . does not try to calm uneven rhythms but, rather, goes with the rhythm set by the person. . . . Moving beyond the moment, reaching the hopes and dreams that have been illuminated, . . . the person, family, or group erupts in explications of the situation that incarnate new meanings. The human becoming nurse lives true presence with others in the processes of illuminating meaning, synchronizing rhythms, and mobilizing transcendence. (pp. 69-71)

One property of nurturing connection that was not widely found in other nursing literature is the notion of serving as a conduit for knowledge from the Mystical Beyond. Parse (1998), however, described the "tacit-explicit knowing of messages given and taken at many realms of the universe" (p. 72). In this Parse acknowledged a take and give interconnection, not only between a nurse and a client in a therapeutic interaction, but within the self, between self and others, and with spiritual phenomena beyond sentient experience.

With regard to the notion of true presence as described in the nursing literature then, nurses live and enact spiritual care through properties of nurturing connection (even when they may not recognize or associate their work with spirituality) in the context of a transcendent and helping relationship with a person, family, or community in need.

The Power and Potential of Changing Beliefs

The next question relates to changes that occur in knowledge and practice as a result of the process of learning how to care for spiritual needs. At first, it surprised me to discover that certain knowledge and practices learned by participants in their formal education and practice environments are sometimes incompatible with the spiritual needs of clients. Beliefs prevalent in the recent history of nursing, such as equating spirituality with religion, believing that religious matters are too private for nursing action, or assuming that patients who describe mystical phenomena are delirious or psychotic, often interfere with nurses' ability to recognize spiritual need. In their family therapy practice, Mcleod and Wright (2001) found that the constraining beliefs of clinicians often, wittingly or unwittingly, curtailed the exploration of spiritual experiences. Moreover, when nurses avoided spiritual questions because of self-centered insensitivity or lack of client-centered curiosity, or when nurses thought they already knew the religious beliefs of a client/family, "such stereotyping always close[d] down conversations" (p. 409). In learning connection the nurses described the process and product of changing beliefs, especially those associated with the confusion between spirituality and religion. Along with blueprints for spiritual well-being obtained through religious beliefs, the nurses came to recognize broader spiritual needs associated with making sense of and finding meaning in health-related events. Facing and sorting through their own beliefs helped them to understand the importance of assisting clients to struggle with spiritual concerns, connect, and find meaning.

Wright, Watson, and Bell (1996) developed a model for family therapy based on the alleviation of suffering through the exploration of beliefs about illness. Beliefs are powerful tools that shape how individuals understand, find meaning, learn, and grow. According to Wright et al., through the process of learning, and especially during illness, beliefs can be challenged, affirmed, and/or threatened. Wright (1999) explained that the experience of illness is influenced by preexisting beliefs and beliefs that evolve during an experience. As well, she stated that individuals and families often reconstruct or redefine their beliefs after an illness episode. Just as beliefs influence client responses to illness, the current research shows that beliefs influence how nurses learn to care for spiritual needs. It was not until the nurses were faced with repeated personal or client situations that challenged their beliefs that they initially held that they learned to recognize certain types of spiritual needs. For example, one participant admitted that, until she came to a point in the development of her own belief system where she could accept witnessing the unusual, she would ignore evidence of mystical experience in her clients. A significant result of the process of learning to care for spiritual needs was the nurses' change in beliefs, which opened the way for recognition and connecting therapeutically to work with spiritual needs. Through changing beliefs, the nurses found the connection between health and spirituality.

Many nurses, such as Parse and some of the other nursing theorists (Martsolf & Mickley, 1998), do not recognize or acknowledge that their work deals with the spiritual.

Even though, as the current research found, nurses unwittingly attend to spiritual needs during routine nursing care, the process of recognizing the spiritual nature of their work often occurs over time as beliefs change. Wright (1999) disclosed that until midway through her career, even though her colleagues and students offered repeated unsolicited observations regarding the spiritual aspects of her work, she had never intended to emphasize the spiritual. Likened to secular theology and the notion of reverencing, Wright's work fostered a deep emotional connection between her and her client(s). Wright described it as "pure love" (p. 63) and witnessed the most profound changes in thinking, behaving, and the perceived experience of illness and suffering. Indeed, akin to the learning trajectories described by the nurses in the current study, she learned through experience that the most powerful aspect of her clinical work was its spiritually base. With a "new trinity" (p. 62), Wright linked three health-related concepts: spirituality, suffering, and beliefs. She emphasized that she found it impossible to consider spirituality without considering suffering and beliefs.

Wright (1997) stated that, in her clinical experience, persons and families cope more effectively if there is an absence of spiritual distress. Describing spirituality as personal belief in the Supreme, an investment in inner values, and a sense of meaning, connection, and inner wholeness, and defining spiritual distress as the inability to invest life with meaning (Burnard, 1987), Wright argued that the goal of nursing—indeed, her obligation as a nurse—was to alleviate suffering. In the current research the alleviation of suffering would fit with other outcomes of needing connection such as feeling more peaceful, accepting circumstances, and finding new meaning. However, a nurse-centered belief in and an agenda to alleviate suffering or thwart spiritual distress (Hood Morris, 1996) may actually interfere with the learning gained through struggle. Hood Morris (1995) discovered that the experience of spiritual distress involves aspects that could enhance or inhibit spirituality. Just as in the current research, where struggle was crucial to the process of connecting spiritually, spiritual distress is often an antecedent of spiritual-well-being (Hood Morris, 1995).

Overall, the ways that Wright (1997) suggested for alleviating suffering are consistent with the findings of Wesorick (1995) and the nurturing connection category of the current research. Interventions include acknowledging, telling, listening, witnessing, creating a healing environment, inviting reflections, and "connecting suffering and spirituality" (p. 8). However, the connection between spirituality and suffering and the nurses' approach from nurturing connection in the current study took shape in a slightly different way. Part of the process of learning to care for spiritual needs entailed a definite shift away from a goal-orientation of fixing a spiritual problem to a process-orientation of facilitating exploration. Connecting spiritually was more about the struggle than about a particular end. From both the patient perspective and the nurse perspective, needing and nurturing connection respectively entailed struggling to connect experiences in a journey of learning and moving towards meaning. Many times the way that the nurses described processes of struggling could be interpreted as suffering. However, even though the alleviation of suffering may have been an outcome of needing connection, it was not the goal associated with nurturing connection. The nurses learned to care for spiritual needs primarily through a process of being fully present with the client's subjective reality and through assisting them no matter what the issue or how painful their reality may have been. The goal was to be fully present in and across moments of need and circumstance.

The path that Wright (1999) described as she came to recognize through personal and professional experience the potential of working with the spiritual dimension demonstrates the power and mechanism of shifting beliefs as a major mode of change in learning to care for spiritual needs. Although, until the current research, the processes that practicing registered nurses have used to learn about spiritual care have not been formally studied, many more stories of changes in knowledge and practice analogous to learning connection were exemplified in the literature (see below: Watson, 2002).

Core Connection

Early in the process of constant comparative analysis after the first few interviews, the core variable of connection leapt out of the data and impressed me with its significance. At first I thought, Well, of course! How obvious! I knew at the time that connection was one of the important themes in the literature on spirituality, but I was unsure whether connection had ever been described as the central phenomenon.

Generally, the concept of connection has not been a major focus in the literature. In nursing, connection has most often been used to qualify another conceptual state such as caring (Clayton, Murray, Horner, & Greene, 1991; Wilde, 1997), spiritual

(Montgomery, 1992), or intuition (Murray, 1989). As well, by comparing several related concepts, Golberg (1998) discovered that both spirituality and nursing care appear to be products of a relationship. As a result, she synthesized the two into one holistic concept, naming it simply *connection*. However, in the literature the notion of connection was rarely described as a process or an action; that is, one of connecting. In a concept analysis of the caring connection in nursing, Wilde (1997) argued that "just as the verb connecting can be viewed as antecedent to the noun connection, connection as an outcome can be viewed as a consequence of the process of connecting" (p. 20). Similarly, in the current research, connection appeared as an antecedent in needing connection, a caring state in nurturing connection, a consequence of learning connection, the outcome of living interconnection, and the overarching basic social psychological process of connecting spiritually. The multiple states associated with connection and the act of connecting were the core of the process that the nurses used to learn to care for spiritual needs.

To conclude this discussion of the process that nurses experience in learning how to care for spiritual needs, I quote the words of a great nursing exemplar. In this piece Jean Watson (2002), a world-renowned and gifted nurse, theorist, researcher, and teacher, poignantly reflected the perspective of needing connection. This perspective of client was framed by other experiences that showed perspectives of nurturing connection, learning connection, and living interconnection. Her life story showed the juxtaposition and exchange of opposing positions and provided a glimpse of the learning process from connecting spiritually through opening, struggling, connecting, and experiencing.

> I live in pain, yet I dwell in a semblance of peace. I know fear, yet I dwell in love. I know terror and life's horror, yet I glimpse joy. I live in darkness, yet I experience light. I know despair, yet I live in hope. I know doubt, I reside in faith.
>
> I live with and witness gut wrenching suffering, . . . I learn deep self-caring and healing . . .
>
> I lose my eye, yet I am sighted
>
> I lose my husband. Yet I am wedded . . .
>
> I lose my life as I had known it . . . Yet I now seek and glimpse another, deeper, inner life . . . .
>
> I am fragile, vulnerable, and labile. Yet I am softened and purified, opened, strengthened by my wounds and my wonder and life and death.
>
> I will never be cured. I may be healed. I am being changed. I AM. (p.181-182)

CHAPTER 6

IMPLICATIONS: RESEARCH, PRACTICE, EDUCATION

The study of connecting spiritually has many implications for research as well as for nursing practice and education. Connecting spiritually primarily pertains to ways of learning and, in particular, how practicing registered nurses learn to care for spiritual needs. Part of the study includes three other substantive perspectives—patient needs, spiritual care, and living spiritually—that intertwine with the main question about a learning process. Therefore, the implications extend to notions of formal learning theories and of spiritual needs, nursing practice, and nursing education. In addition, the findings related to the background for this study, human spirituality, lead to implications for methodological consideration.

Research

The first implication for research pertains to findings associated with experiential learning theories. The theory of connecting spiritually emerged from a study of practicing registered nurses who retrospectively narrated their experiences with learning about spiritual care. The findings in this study generally fit with other models of experiential learning. However, this study addresses areas that extend other models published in the literature. These include (a) the addition of the components of intentional opening and emotional aspects of struggle to the process of learning, (b) the facilitative function of shifting between opposing positions of take and give, (c) the notion that background perspectives provide integral support and context for experiential learning, and (d) the idea that the steps and phases of the learning process are highly complex, more intertwined, yet still generally cyclical and linearly progressive in nature. The explanation for some of these differences remains unclear. Were the current findings a specific consequence of the retrospective narrative design of data collection, or might the results have more to do with the underlying substantive area of study, human spirituality?

The issue of how best to nurture spiritual health and study aspects of human spirituality leads to methodological questions. Because of the highly subjective and intangible nature of the spiritual dimension, aspects of spiritual health have been difficult to study with traditional empirical research methods. Grounded theory methodology stems, in part, from objective and positivistic roots, yet it leans heavily towards a subjective and interpretive research paradigm. With a grounded theory method, Glaser's (1978) and Glaser and Strauss's (1967) goal was to discover a basic social or social psychological process used by a group to deal with a common problem. The question is whether a grounded theory method meets the requirements for research issues of a spiritual nature. Grounded theory method is rooted in the theory of symbolic interactionism and field methodology (Stern, 1980). Symbolic interaction suggests that people do not merely respond to the actions of another, but that part of the interactive process entails interpreting and attaching symbolic meaning to another's actions before responding. The process of making meaning serves to mediate the interactive response. The spiritual dimension also pertains to notions of relationship and meaning. However, what is not a specific focus in a grounded theory method is the influence of broader spiritual notions of interconnection, experiential meaning, and ultimate purpose. Questions for further research arise. Are there different kinds of processes associated with the spiritual component of human existence? Is there a basic spiritual process? Is there a physical process that is connected to the psychological and social? Are psychological and social processes only the tools for a spiritual process? Or are spirituality and/or spiritual well-being only results of a basic social psychological process? Is there a way to broaden the scope of grounded theory method?

The scope of this study was limited to the perspective of practicing registered nurses. All of the participants are female; therefore the findings are limited to the perspectives of women. Despite the fact that no men volunteered for the study, the role of gender did not arise as an issue for theoretical sampling. Therefore, the male perspective was absent and not purposely sampled. However, some contend that the caring knowledge and practices of men are different from those of women. It remains unknown whether the process and experience that male nurses use to learn how to care for spiritual needs vary from the female perspective discovered through this study. In addition, in the process of following a particular theoretical issue, the current study includes a perspective from only one other health care discipline. The limited scope of this study indicates further research in order to study and compare the spiritual care perspectives of male nurses and professionals from related health care disciplines.

Practice

The findings from the current study imply that nurses in direct clinical practice need more formal and informal support in order to recognize and value strategies that address spiritual needs. This study shows that most current methods that nurses use in routine nursing care also apply to practices of spiritual care. Some of these strategies include being client-centered, engaging with presence, and practicing appropriate personal and professional boundaries. Many nurses complain that modern practice demands leave insufficient time to care for spiritual needs. However, patient perspectives in this study suggest that it is not so much the amount of time that it takes to intervene spiritually, but rather the quality of openness, respect, and attention that nurses use to care that makes a significant difference in spiritual care outcomes. Commenting on a recent study of the spiritual perspectives of American nurses, Buchanan (2004) suggested using the works of Parse and Wright for frameworks to help nurses learn to be present and to explore beliefs. As reinforced by the findings of the current study, these tools are "conducive to nurses' spiritual practice" (p. 215).

This study clearly demonstrates how nurses develop knowledge for spiritual care, not just through formal education, but also over the course of their careers. These findings will help nurses and their employers to recognize, support, and promote the role and value of experiential learning in clinical practice. The study shows how learning to care for spiritual needs entails connecting personal and professional experience over time, with an active sense of openness and struggle and an intention to find and help to find meaning.

Education

With few exceptions, the nurses in this study were unable to identify a specific theory base for practicing spiritual care that they learned through formal nursing education. Benner (1984) maintained that novice nurses, as well as nurses implementing new practices, initially rely on certain rules or guidelines from formal theory and education. However, in this study, even without formal instruction, the nurses attended to spiritual needs using an ongoing process of experiential learning. This implies that the process of acquiring the knowledge and skills to care for spiritual needs never ends, but continually evolves over time. Practicing nurses need to actively open to, reflect upon, struggle with, consolidate, and test strategies for helping clients with diverse spiritual needs. These findings are consistent with the principles of adult learning. One of the broader issues concerns how to facilitate experiential learning in formal educational settings. Recent education initiatives in context or problem-based learning pedagogies in nursing educational programs draw more on experiential learning methods than on traditional didactic methods. Consistent with adult learning models, students actively engage with and take responsibility for acquiring essential knowledge and skills. Curriculum developers and nurse-educators need to ensure that spiritual needs and spiritual care concepts are integrated into the core concept map of a curriculum. Like the learning objective of cultural competence, nurses, educators, regulators, and employers need to facilitate and ensure the development and maintenance of the knowledge and skills for spiritual competence. Some strategies might include specifying spiritual competence as a measure for consideration in periodic professional reviews (e.g., annual performance evaluations and regulatory learning plans, peer supervision) or facilitating professional development through staff meetings, journal discussion clubs, and retreats.

Finally, the link between health and spirituality needs to assume a higher profile in the broader realm of health care delivery. The perspective of the nursing discipline offers a great deal to other partners in health care. In Canada over the past few years there have been several multidisciplinary conferences specifically aimed at exploring issues of spirituality and health. Through these and other venues, nurses have contributed to the growing academic and practical forums for knowledge dissemination. At some academic institutions, nurse educators have begun to collaborate with related health specialists such as those in pastoral care to research and develop learning tools and courses related to spirituality (see Clark & Olson, 2000). The current study indicates a need for a more concerted effort to continue to develop interdisciplinary collaborative initiatives in order to further capitalize on knowledge resources and enhance the quality of spiritual care.

Conclusion

This study began with a broad question about how nurses acquire knowledge for spiritual care. Not only did the question lead to findings about ways of learning, but the study also implied that the very nature of the way that nurses do their work stems from the spiritual dimension. Using the self as a therapeutic tool, nurses routinely connect with spiritual need through a deliberate client-centered caring presence. This deep connection fosters client well-being, but also, in linking numerous past experiences with present, a nurse derives personal meaning and learns new skills to offer future caring occasions. Past, present, and future experiences merge in a transcendent connected, meaningful, purposeful, and spiritual reality.

Despite some uncertainty, yet with a growing social and professional mandate, nurses must continue to learn and use knowledge related to matters of spirituality, spiritual need, and spiritual care. This study has demonstrated the multiperspective, intertwined, never-ending process of connecting spiritually in order to learn how to care for spiritual needs. Knowledge acquisition may begin during, and even before, formal education; but it is important that practicing registered nurses recognize the value of experiential learning for personal spiritual health as well as in assisting clients to explore spiritual concerns. The findings from this study bridge the realms of nursing research, practice, and education and contribute to a growing body of spiritual care resources for building capacity among nurses.

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APPENDIX A

STORYLINE MEMO: LEARNING TO CARE FOR SPIRITUAL NEEDS

Appendix B: Storyline Memo: Learning How to Care for Spiritual Needs

Thinking back, it is hard to pinpoint how and when I started to learn about spiritual care. At first I think we nurses thought that spirituality was the same as religion, and back then you wouldn't dare bring up religion with a patient. Now I think spirituality is so much bigger than religion. It is not that religion is not part of spirituality; it is just that, well, everyone, whether they are religious or not, needs to believe in something and connect with others in meaningful ways. That said, being raised with Christian ideals certainly influenced my choice of nursing. I wanted to help my patients as best I could. At first I thought we'd be taught what to do or say to fix patients problems; you know, the right words, the right remedy, the right skill. But I don't remember learning anything in particular about spiritual care back then. Sometimes I'd feel so lost. One day I saw a woman throw her Bible and shout at her Pastor, "God couldn't know!" Later that evening, I cautiously inquired about what had happened. Not knowing what to say, the best I could do was listen. She cried and complained about him, suggesting she just had to have more faith. Really, I didn't know what to do, except pass the Kleenex. I was amazed when she *thanked* me! Afterward I wondered: What had I done? What really made her so angry? What did she need from him that he didn't give?

Thinking about her situation reminded me of losing my baby. You see, I still blamed myself. I hadn't paid enough attention to ominous symptoms that, as a nurse, I should have known. Like her, I couldn't forgive myself. Although I connected on a personal level with her situation, I had lost faith in myself and didn't think I could do much of anything to help her. Even so, I realized that she appreciated me listening to her. So after that I began making more time to spend listening to my patients.

Then, years later, on the anniversary of my baby's death, I found myself in hospital having a hysterectomy! I must have seemed a little off to the nurses. There was no privacy. Late at night a nurse found me hiding in the washroom. I guess she could tell I was crying. She came right in and closed the door. She asked if I needed to talk. Whatever she said made me trust her, and the floodgates just opened. I told her how I believed I killed my baby, but everyone around me had grown weary of hearing me blame myself. They just wanted me to forget it and move on. I felt so guilty. All of a sudden the story of the woman and her Bible came to mind. Like her, I even thought God was punishing me by taking away my womb. Seems kind of incredible now to think that I really believed that back then, but I did.

But the care of that nurse was different. Not once did she deny that I was responsible. Instead, she listened and listened. I remember she even helped me rip off some toilet paper for my nose. [laughs] She crouched down holding my arm while I sat on the toilet blithering and wiping away tears. But with her it was different from my nursing experience. She didn't seem scared at all, at least to me. She said, "It must be horrible to lose something that is so precious to you and feel so responsible for so long. I've known other women who've told me it is like they feel dead too." She hit the nail right on the head! We talked a bit more about God and those still-raw feelings. I think it was just feeling heard that meant so much. The whole thing must have been over in five minutes. But for me, that was the turning point. I think we really connected that night, connected too with others I have nursed in the past. I know, for me, I no longer felt alone with my burden. The lights came on and I was finally able to let go of the guilt. I was probably just another patient to her, but I will *never* forget what she did. She took a little bit of me and fed it back. This helped me reconnect with the spirit in my life again.

Not only that, when I got back to work, I started to do things a bit differently. I realized how helpful it was for me to just have somebody to hear me out and not tell me I was wrong. So I made a point of trying to take time to ask my patients what was on their mind each day. Then I'd just listen carefully. I'd try not to judge. It is kind of like the Golden Rule you know, do onto others how you'd like it done for you. I remember it was easier to do on evenings and nights. Often I'd be reminded of my own experience or what other patients had told me. Like that nurse had done with me, sometimes I'd share some of those experiences, anonymously of course.

There came a point when I realized that I no longer felt like I had to have all the right answers. I didn't need to tell my patients what to do, I just needed to listen and in a small way help them to figure it out for themselves. Sometimes they just needed someone to be there to acknowledge how awful circumstances were for them. Sometimes they'd ask questions about God and stuff that I couldn't answer. Usually I would ask if they wanted me to make a referral to pastoral care. However, most times they just needed a few moments of my time to hear them out and help them find their own meaning. Gradually, I began to feel closer and closer to my patients and I liked my job better and better.

There have been times though when it wasn't that easy for me to face what happened at work. For instance, I remember a woman who described spiraling up to a bright peaceful perch before being sucked back to the OR table. I ignored it. You see, I didn't have room in my belief system for the possibility of those kinds of mysterious things. So, how could I have recognized them as spiritual needs? Through experience, I gradually learned to be more and more open to accessing what was actually happening and helping my patients explore the meaning and purpose of the lessons embedded in the experience.

I remember another time when an aboriginal man was badly burned in a car accident. He lost limbs, thought he'd been cursed, and ended up on life support. He wished they'd just let him die. He was so angry at all of us, and at the Creator. I'll never forget the day he asked me to help him "push the delete button." Again, I didn't know what to say or do. But I have this guardian angel that sits on my shoulder and reminds me when I'm too close to danger. Like the time something told me I'd better check on him and, sure enough, he was in deep trouble. That sixth sense stuff happens a lot with nurses. That has to be spiritual too. Anyway, with him, I often felt exhausted and couldn't get him out of my mind. Late one night I remember comparing this man's struggle to mine. My thoughts were so conflicted. Then it came to me how I had learned the most from the hardest experiences. That helped me let go of the pain of his predicament.

As awful as it was, I know that I am a better person and a better nurse because of those hard times. Dealing with ethical dilemmas over the years has helped me see that there is something to be learned from bad things. I no longer waste time blaming myself, blaming others, or blaming God. The important thing to me is finding or helping someone else find the lesson in it all. I guess dealing with him and others like him really changed what I believe about the purpose of things that happen in life.

But issues like that happened less and less as the years went by. I learned not to take on my patients' problems and struggles. I could be there with them in their time of need but I had to separate what was theirs and what was mine. So, if I was troubled after work, I learned to just spend a moment in prayer and give up to God. One time I went to one of those energy workshops and learned a grounding technique. When I felt emotionally drained after work, I'd try it. Incredibly it usually reenergized me. That and some other stuff I learned through the Holistic Nurses group has helped me take care of myself. Nurses need to learn to detach themselves from their patient's problems. And that does not at all mean that they don't care. It is just that the problem is not theirs. Nurses have to be part of the solution, the way through, I guess. They need to learn to be there, to walk beside their patients as they make their way through troubled times.

I am older now. I don't know everything there is to know about spiritual care, or for that matter, my own spiritual needs. But one thing I know now is life, especially the spiritual part of it, is a journey. So far it seems that I've learned about spiritual care in pieces. Most of it was through the problems I had to face. A lot came from just the experience of being cared for in a way that helped connect and heal me from way deep inside. I learned to listen closely and take a bit of what they gave me and feed it back. It is kind of soul to soul, being right there, I guess. I expect that ten years from now I'll have encountered another piece of the lesson. As a result, I'll probably see and maybe do things a bit differently. That's the beauty, that's the hope, that's the growth.

APPENDIX B

ADVERTISEMENT: ACQUIRING KNOWLEDGE FOR SPIRITUAL CARE

Appendix B: Advertisement: Acquiring Knowledge for Spiritual Care

Acquiring Knowledge for Spritual Care

Research Study

Seeking

Registered Nurses

in

Direct Clinical Practice

for

Interviews

related to

Knowledge and Experience

of

Spirituality and Spiritual Care

Investigator:
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APPENDIX C

ACQUIRING KNOWLEDGE FOR SPIRITUAL CARE: INFORMATION LETTER

Appendix C: Acquiring Knowledge for Spiritual Care:

Information Letter

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INTRODUCTION:
Part of the professional role of registered nurses is to care for the spiritual needs of clients. Yet, amongst practicing registered nurses, considerable uncertainty exists regarding human spirituality, spiritual needs, and spiritual care. Beyond a few studies done in formal education settings, no research has explored the process used to acquire and maintain continuing competence related to the practice of spiritual care. As a practicing registered nurse, I am inviting you to participate in this research study.

PURPOSE OF STUDY:
Understand how nurses learn about spirituality and the practice of spiritual care.

PROCEDURE:
I will collect data in the following ways:

1. Interview registered nurses who are willing to talk about incidents of spiritual care and the ways and means of acquiring knowledge related to that practice.
2. Invite participants to offer additional written information that may arise from private reflection after the initial interview.
3. If initial analyses warrants, interview students in a baccalaureate program leading to nurse-registration nearing the completion of the practical part of their program.

What will happen:

Interviews will last not more than two hours and will be conducted at a mutually convenient place and time outside of your normal work schedule. The interview will be audio recorded. I will ask for your thoughts about human spirituality, spiritual care, and what it is like to learn about that aspect of your nursing practice. You can talk about whatever you think would be relevant to the study.

Sometimes people who participate in a study like this are reminded of relevant information after the interview has been completed. I am interested in all thoughts you have related to how nurses acquire knowledge for spiritual care. If you want to add to the information you have provided in this interview, you can mail or email me your written reflections. The time you spend on this is up to you, but should take less than an hour.

I may invite you to participate in a shorter follow-up interview, lasting less than an hour, to clarify points raised by you or to delve further into those areas.

Risks/benefits:

Some report positive feelings after sharing the kind of information this study seeks. There are no known discomforts or risks expected with this study. If, however, at any time you need to take a break or completely stop, you may do so. In the unlikely case that you experience residual psychological or spiritual discomfort, you are encouraged to contact a professional through your employee assistance program or a chaplain.

Privacy and Confidentiality:

All information will be kept confidential except when a professional code of ethics or legislation requires reporting. For this study, other than small examples of dialogue that may be used in publications and presentations, only my committee members and I will have access to the study notes. Your name or any other identifying information will not be attached to the information you give. All information will be stored in a secure area and kept for at least five years after the study is done. The information gathered for this study might be looked at again in the future to help us answer other questions that relate to the study. In such cases, other researchers may need access to your information. If so, an ethics board will first review the new study to ensure your information is used ethically.

Freedom to withdraw:

You may, at any time, withdraw from the study. There is no penalty for withdrawing. Participation in this study will never directly affect the conditions of your employment or your academic standing.

Voluntary Consent/right to refuse:

All who participate in the study must consent voluntarily. You are encouraged to ask for clarification about any part of the study. You are free to refuse to respond to any question. You can stop the interview at anytime.

Additional contacts:

If you have any questions, concerns, or comments about this research, you can contact Elizabeth Hood (780-492-6250) or Dr. Joanne Olson (780-492-4338). You also may address concerns of any aspect of the study to Dr. Kathy Kovacs Burns, Research Office, Faculty of Nursing University of Alberta (780-492-3769). This office has no direct affiliation with the study's investigators.

How the information will be used:

The information you provide will assist in the clarification of ways, means, and the process registered nurses use to acquire knowledge for spiritual care. It will serve to sensitize nurses and others to human spirituality and spiritual care. A report will be written about the study. Findings will be disseminated through publications in academic journals, workshops, and conferences. A summary of the study will be made available to those who make a request.

Initialled: __________/__________
Participant/researcher

APPENDIX D

CONSENT FORM

Appendix D: Consent Form

Project Title: Acquiring Knowledge for Spiritual Care

Investigator:
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Do you understand that you have been asked to participate in a research study? Yes No

Have you received and read the attached Information Sheet? Yes No

Do you understand the benefits and risks involved in participating in this research study? Yes No

Have you been able to discuss or ask questions about this study? Yes No

Do you understand that you are free to withdraw from this study at any time and that you do not have to give a reason? Yes No

Do you understand that participation in this research study will not directly benefit you in any way? Yes No

Has the parameters of confidentiality and anonymity been explained to you? Do you understand who will have access to the information you provide? Yes No

Do you understand that your name will not be associated with any of the information you provide and that all identifying information will be removed from the records? Yes No

This study was explained to me by: ________________________.

I agree to take part in the following aspects of the study.

1. Permission to be interviewed Yes No
2. Permission to review your written work Yes No
3. Permission for the researcher to revisit your data if relevant to future studies Yes No

________________________ ________________________ ________________________
Signature Date Printed Name

I believe that the person signing this document understands the parameters of the study and voluntarily assents to participate.

________________________________ ________________________
Signature of Investigator or Designee Date